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Vol. 1, No. 1
Fall 1996

MASA REVIEW

Incorporating **Alabama Medicine,**
The Journal of the Medical Association of the State of Alabama

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Why MASA Review?

"The collective sum of all printed knowledge is doubling every four years. More information has been produced in the last 30 years than in the previous 5,000... And it's only getting faster and more out of control....

"Information without knowledge. On the surface it provides convenience and promises new possibilities. But without discipline, it is more destructive than progressive.

"Since 1978 capital investment in information technology has increased 10,000%. In that same time, productivity hasn't much changed. ATMs have increased bank fees, electronic filing has led to fraud, Jiffy Lube has replaced the relationship with a trusted mechanic, and 24-hour customer service only works in a world of diminished service expectations.

"Today everything is available instantly. It's all about being on the scene in real time. The problem is, getting to the scene quicker doesn't make us any smarter.

"Information is not synonymous with knowledge. One is about facts, the other about understanding." **[Emphasis ours]**

The speaker of these words, somewhat surprisingly, was Barry Diller, former head of Fox, Paramount Pictures and sundry other entertainment kingdoms, and now chairman of the mammoth Silver King Communications. These words, extracted from a closing speech earlier this year, stunned an elitist conference of his fellow multimedia moguls. They had spent two glorious days in self-adulation as purveyors of just the kind of paradox Mr. Diller was addressing - information without knowledge, without understanding.

And what have his welcome fulminations got to do with this, the first issue of MASA Review? Quite a lot, we believe. As it happens, the Board of Censors has been agonizing over the roles and missions of the Association for the past two years. Specifically, the Board has been diligently addressing the famous question Management Expert Peter Drucker posed for every corporate entity in the land: "What business are we in?"

As you probably know, major industries devoted thousands of hours to producing their answers. Simple as it sounds, it is an extremely difficult question. Some industries, whose names had been household words, frankly confessed they no longer knew. But even they were far better off than those who dismissed the question as frivolous. They had to find out the hard way – from their rebelling customers or clients. A few years back, among those who flunked was IBM. Its comeback, correspondingly, was the result of finally answering the question with a wrenching reorganization top to bottom.

When Alabama Medicine was born (as the Journal of the Medical Association of the State of Alabama) in 1931 it precisely filled a real contemporary need. Alabama doctors of that period needed a clearing house for new medical knowledge, the delivery of which had been haphazard at best. Reading in the archives of the Journal from the 30s to as late as the 60s, you see many examples of physicians sharing what they had learned about new therapeutics.

Some of the reports were only a few paragraphs in length, but they contained vital experiences of doctors in the trenches dutifully obeying the Hippocratic mandate to share their knowledge, to teach the art.

Obviously this system had it shortcomings, but for the time it was substantial progress. That scientific function of state medical journals has now been assumed by the national specialty journals, which have become highly skilled at separating the wheat from the chaff. In the fullness of time, the state journal scientific article became an anachronism, a redundancy, a poor substitute for the scrupulously peer-reviewed articles in the specialty publications.

In the past 20 years, state journals had already begun publishing more articles of non-scientific content. Similarly, Alabama Medicine, the new name given the Journal in the 1980s, began to involve into a new form, more or less autonomously. It began to welcome, for example, manuscripts from lawyers explaining the new pitfalls of practice, notably in professional liability, which was not a worry in 1931, and articles from other experts detailing the rapidly changing socio-economic face of medicine.

MASA Review, then, is one result of many intense discussions of what member physicians need now. Quite obviously, those needs are very different here in the 10th decade of the century than were those of their predecessors in the third and fourth decades, light years away as time is reckoned in modern medicine.

This first issue is, almost by definition, a prototype. Plainly, there is no formula, nor is there likely to be one. The general idea is that The Review's content will float on the winds of change, whatever the direction.

While it will contain locally written articles, it will also look to other medical journals for articles of value to Alabama doctors. This strategy is predicated on the informed belief that the wider the sampling of physician thinking on the problems besetting medicine, the more rational will be the choices doctors make For some questions there are no quick and easy answers, no bright-line distinctions between right and wrong, black and white.

An example of this will be found on page 11 in the comments of Dickerson Hollister, Jr., M.D., President of the Connecticut Medical Society, on electronic patient records. Dr. Hollister confesses to an ambivalence shared by many Alabama physicians. He thinks electronic records can be a great boon to patient care, but he is also deeply concerned about the implicit risks to confidentiality, a central pillar supporting the doctor/patient relationship.

MASA President Craig H. Christopher, M.D., is the first leader of the Association to emphasize the transformations and dislocations of the Third Wave, in which medicine is now awash. See Executive Director Lon Conner's column, page 6.

P. John Seward, M.D., AMA's new Executive Vice President, speaks of the changes and challenges facing his stewardship, page 13 .

Selma Psychiatrist David W. Hodo, M.D., reminds us of medicine's legacy in his review of Hippocrates in a World of Pagans and Christians by the Emeritus Professor of the History of Medicine at Johns Hopkins, page 16.

Physicians who put the practices on the block are not always prudent sellers, as revealed in a definitive article on "Pricing Your Practice" from Texas Medicine, page 20.

The conventional wisdom of the managed care crowd that one of their principal savings lies in avoiding specialists is a phony economic theory, writes Birmingham Rheumatologist David A. McLain, M.D., page 23

Don't talk to sick patients about money advises Alabama physician M.J. FitzGerald, M.D., page 26.

While Americans don't want to see the medically indigent dying in the streets, believing that everyone is entitled to some low minimum of health care, neither do they believe in equality across-the-board, says health care pun-

dit Uwe Reinhardt in an interview with New Jersey Medicine, page 32.

There is no stimulus in the system to reduce the number in residency training, writes the American College of Surgeons' Paul A. Ebert, M.D., in the ACS Bulletin, page 34.

Practical advice from Blue Cross/Blue Shield of Alabama on correct Medicare Coding Combinations can be found on page 36.

The remarkable story of the Confederate Soldier, Surgeon and Author John Allan Wyeth, M.D., is retold by a gifted Alabama medical historian, Plastic Surgeon Paul S. Howard, M.D., page.

The five-part series on computers and the internet by retired Surgeon Ernest S. Campbell, M.D., prompted many requests for reprints after it appeared in The Alabama M.D. during the summer. Groups as diverse as the Alabama Society of Certified Public Accountants and Delaware Medicine asked for and received permission to publish one or more of the articles. Many Alabama physicians have requested reprints for their personal use. Here is the series, reprinted in its entirety, beginning on page 45.

Mrs John O'Toole, A-MASA President, introduces her account of the Alliance's work in combatting domestic violence with a dramatic and affecting account of the childhood of a person very close to her, page 63.

And so on in this our first effort to provide a vehicle for collecting the knowledge and wisdom that is out there in the various publications of the profession. We agree with Barry Diller that information in this Information Age is not synonymous with knowledge; that one is about facts, the other about understanding. MASA Review will attempt to mine the rich vein of understanding and wisdom from across the country. We welcome suggestions.

– The Editors

EXECUTIVE DIRECTOR

S. Lon Conner
Executive Director, MASA

Riding The Third Wave

MASA President Christopher H. Craig, M.D., is a man with a mission: to alert his fellow physicians to the fact that they are already deeply immersed in an entirely new social and economic order, one famously described 16 years ago by a prophet who was destined to become maven and mentor to that self-described firebrand of revolution, Newt Gingrich.

The prophet was Alvin Toffler, who wrote in his 1980 book, The Third Wave:

> **A new civilization is emerging in our lives, and blind men everywhere are trying to suppress it....**
>
> **Until now the human race has undergone two great waves of change, each one largely obliterating earlier cultures or civilizations and replacing them with ways of life inconceivable to those who came before. The First Wave of change— the agricultural revolution—took thousands of years to play itself out. The Second Wave—the rise of industrial civilization — took a mere three hundred years.**
>
> **Today history is even more accelerative, and it is likely that the Third Wave will sweep across history and complete itself in a few decades.We, who happen to share the planet at this explosive moment, will therefore feel the full impact of the Third Wave in our own lifetimes.**
>
> **Tearing our families apart, rocking our economy, paralyzing our political systems, shattering our values, the Third Wave affects everyone. It challenges all the old power relationships, the privileges and prerogatives of the endangered elites of today, and provides the backdrop against which the key power struggles of tomorrow will be fought**
>
> **Much in this emerging civilization contradicts the old traditional industrial civilization. It is, at one and the same time, highly technological and anti-industrial.**

Toffler had already won the attention of thoughtful Americans with an earlier work, Future Shock. Thus The Third Wave was received with trumpets of praise by the relatively small number who shared his vision. But the great majority, if they had heard of the Tofflerian warnings at all, dismissed him as just another Cassandra screaming that the sky is falling.

Re-reading the Third Wave in 1996, you are struck with the fact that it all seems strangely commonplace. The world Toffler saw emerging in 1980 is all about us. The Third Wave, the

Information Age, has long since crashed ashore and flooded the landscape. It is now rapidly engulfing medicine.

In a sense, Dr. Christopher has waded in all three waves. He was born on a First Wave farm between Fort Payne and Valley Head. He enrolled at the University of Alabama determined, at first, to be a chemist, which would have placed him in the Second Wave of industrial civilization. When he was in Medical School, Birmingham was still a capital of the already declining empire of Second Wave heavy industry.

As the first MASA President to declare coping with the postindustrial Information Age the highest priority of the Association, Dr. Christopher has committed himself to riding the breakers of the Third Wave. He did that in his brief remarks at annual session in April.

Medicine finds itself at ground zero of the intersection of three dynamic forces of change, Dr. Christopher said.

First, is the major global change of the Third Wave, as the world converts from an industrial to an informational economy.

Second, is the big business influence on the management and marketing of health care, specifically the emergence of HMOs, big hospitals, and the continuation of traditional government programs.

Third is the explosion of scientific and medical knowledge with the resultant rise in the influence of specialty societies.

All these forces, he continued, combine to mandate changes in the fundamental structure and mission of MASA. To answer the changing needs of physicians, it must become an information hub to provide them with every resource they will need to meet these new challenges. Dr. Christopher sees the Association's emerging role as an active partner of every member physician, providing each with the information essential to the survival of efficient yet compassionate, patient-directed medical practice.

It is, he said, a profound challenge but one that must be met if MASA is to remain relevant to the rapidly changing professional needs of Alabama doctors. Many beginnings have already been made, one being the Masalink site

55 Minutes To Paradise

On the cover, MASA President Craig H. Christopher, M.D., has just arrived at his beautiful, modern waterfront home on Lake Mitchell, near Clanton, less than an hour's commute from his Birmingham office. He and his wife Millie have lived here for five years, spending five nights a week at the lake and two nights a week at a small house they retain in Vestavia. A wide deck gives them a panoramic view of the lake, just 20 feet beneath. The wind and rain of 1995's Hurricane Opel undercut some of the pilings beneath the deck, requiring 120 tons of rock to be hauled in for shoring.

They grow roses and are working on a shade garden, which will contain indigenous plants that have already demonstrated their capacity to survive in shawdowed areas of the forested land abutting their home. That is an experiment in progress, with results to be announced, they say. Dr. Christopher has added rock wall building to his skills but confesses that his back sometimes takes a beating from the new art form. Visitors to the Christopher home are immediately struck by the grandeur of the site; and they are met by a golden retriever whose appealing idea of hospitality is to offer new arrivals a frisbie to throw.

now being constructed on the World Wide Web (http://masalink.org). Ultimately, this service should provide immediate access to virtually every kind of information physicians will need as the 21st Century sweeps in. As needs change, so will the on-line resources.

By way of illustrating the explosion of technological forces shaping medical care, Dr. Christopher noted that when he entered medical school 30 short years ago there was no neonatal ICU in Alabama; no transplant program; no laser, CT, sonar or MRI.

But also in those three decades, insurers have transformed themselves from passive payers to active participants in medical decision-making, most notably in the case of managed care entities. Hospitals back 30 years ago were content to provide only inpatient medical care; now, led by aggressive marketing departments, they are spreading out in all directions, accompanied by anxious academic medical centers with their satellites.

Medicare and Medicaid have progressed from merely disbursing for care to controlling and rationing it in a variety of ways. (It comes as a surprise to many Alabama doctors that Medicaid pays for 46% of all births in this state.)

Similarly big business, in its new role of "prudent buyer" of medical care, now has has a far more profound impact than 30 years ago, particularly through the influence of self-insured programs that define and restrict covered services, what might be called "designer health care."

When Craig Christopher was coming of age in Fort Payne, it was chemistry that first turned his career aspirations into the general direction of medicine, although medical school had not entered his thinking at the time. It was not until he was in college at the University of Alabama that he became disenchanted with a discipline that seemed so impersonal, so removed from human contact. Medicine then became the only logical choice for joining science and humanity. He has never regretted the change of heading.

While many physicians are apprehensive about the commanding influence the information age has gained on medicine, Dr. Christopher believes it will turn out to be a blessing, eventually giving doctors more time with their patients. And, he adds, it must be remembered that half the practicing physicians in the state are 40 and under. To this age group, neither cyberspace nor managed care is as alien to medicine as both may seem to physicians whose professional lives have been spent in the cottage industry now at risk.

For its part, Dr. Christopher believes, the Association must tool up to perform as the knowledge base for every kind of readily available information the practicing doctor might need. Work on that hub is already well under way.

Dr. Christopher earned his B.S. degree from the University of Alabamain 1966 and his M.D. degree from UAB four years later. After a rotating internship in Medicine and Surgery at UAB, he completed his residency in ObGyn there in 1974. He has served in various capacities with the Jefferson County Medical Society, including the presidency in 1991. He has also served as President of the Jefferson County Ob Gyn Society, and on the Board of the State Society, and as Chairman of the Ad Hoc Committee of the State of Alabama for Obstetric Standards, and as President of the Charles E. Flowers Society, named for the physician principally responsible for rebuilding UAB's department of OB-Gyn to its present standards of excellence.

Dr. Christopher has a grown son working in Atlanta and a daughter now in graduate training in sociology at the University of Arizona.

Dr. Christopher and his wife, Millie, divide their time between a small house in Vestavia, where they usually spend two nights a week, and five nights a week at their beautiful new lake home at Verbena, near Clanton — a 55-minute commute from Dr. Christopher's Birmingham office. See sidebar.

MASA members are fortunate in having as their President a physician who can relate to all their present concerns but who also has an unclouded view of the spectacular challenges already shaping medicine for the 21st. century. ▼

Some Consumer-Oriented Magazines Better Than Others On Nutrition

American Council on Science and Health*

Consumer-Oriented Magazines Outrank Others on Quality of Nutrition Coverage American Council on Science and Health* Popular magazines continue to improve the quality of their nutrition coverage, according to the latest survey conducted by the American Council on Science and Health (ACSH). Fifteen out of 20 magazines reviewed in this .sixth ACSH survey were rated as reliable sources of nutrition information.

Four ACSH judges, each one an expert in nutrition and/or food science, rated eight randomly selected articles from each of 20 popular magazines. The articles were rated on whether the information provided was factual, whether the presentation of the information was objective and whether the nutritional recommendations were sound.

- Three magazines---Consumer Reports, Parents and Better Homes and Gardens---topped the list with accuracy ratings of 90% or more, ratings that the survey classified as "Excellent."
- Twelve publications---Reader's Digest, Cooking Light, Good Housekeeping, American Health, Glamour, Mademoiselle, Prevention, Self, Woman's Day, Redbook, McCall's and Health---received scores between 80 and 89%, earning them ratings of "Good."
- Men's Health, Runner's World? New Woman and Vogue were rated between 70 and 79%, which earned them the designation "Fair." All four showed plenty of room for improvement in their nutrition coverage.
- Only Cosmopolitan, with a score of 69%, was ranked as "Poor"—a rating it also earned in the previous two surveys.

In this latest survey, for the first time, ACSH evaluated groups of magazines based on their target audiences. When surveyed collectively, consumer-focused publications (Consumer Reports, Parents and Reader's Digest) had the highest group score, followed by the home-focused magazines such as Better Homes and Gardens, Cooking Light and Good Housekeeping. Surprisingly, neither health-focused magazine.s nor women's magazines fared as well when surveyed as groups. Both groups earned average ratings of 82%.

Dr. Manfred Kroger, who has judged each ACSH survey, described the welcome changes in the magazines' nutrition coverage. According to Dr. Kroger, "Reporters, writers and editors are doing a better job.... The media are increasingly relying on experts to scrutinize their output before going public, a welcome trend."

Although the ACSH survey found a distinct overall improvement in the magazines coverage of nutritional topics, the judges still noted some inaccurate reporting and sensationalistic coverage of "hot" topics. As ACSH President Dr. Elizabeth Whelan warns: "The consumer must make his or her own decision about what to believe or what advice to follow. If a claim sounds too good to be true, or promises a quick fix for a complex condition, verify it with reputable professionals before following it." ▼

*ACSH is a nonprofit, tax exempt consumer education association directed and advised by over 250 prominent physicians and scientists. 1996 Broadway, 2nd floor, New York, NY 10023-5860 1995 Broadway, 2nd floor, New York, NY 10023-5860

The Physician Workforce in the Next Century

by Richard Nelson, M.D.
*In Iowa Medicine**

For several decades considerable effort has been expended to predict future physician workforce needs in the United States. Within recent months well-publicized studies have suggested the possibility of emerging physician surpluses, surpluses that could result in diminished productivity, loss of physician income and even unemployment.

In an article in *JAMA*, Cooper has provided a useful construct for evaluating this issue (274:1534, November 15, 1995). He suggests that the workforce requirement should be defined by three factors: physician utilization in group and staff-model health maintenance organizations, physician distribution and the future supply of nonphysician clinicians. Mathematical projections using these factors predict a surplus of 62,000 physicians (8% of practicing doctors) by 2010, with a subsequent narrowing of the supply in contrast to demand.

This projection is not as dire as others, but confirms that physician demographics will continue to be a major factor in shaping the health care delivery system. It also suggests that Iowa will continue to be a magnet for physicians seeking relocation opportunities from states that are "oversupplied."

Physician demand is not only determined by the size of the population, but its nature as well as other health care resources available to address needs of people.

Physicians may not have the option of concluding that they do not need to know or do something.

What have these workforce issues to do with continuing medical education? A great deal. As physicians increasingly become part of health care systems, their responsibilities will of necessity complement those of colleagues. Physicians may not have the option of concluding that they do not need to know or do something because patients will have access to care elsewhere. That care may have to be provided by the physician in question. For many of us it is time to search the Internet and CME course directories for what we need to be contributing members of the 21st century workforce. ▼

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The Electronic Medical Record
Good News and Bad News

by Dickerson Hollister, Jr., M.D., President
Connecticut State Medical Society
*In Connecticut Medicine**

Virtually all business and industry is now dependant on the computer. Goods and services are managed instantaneously by the electronic flow of infommation. In medicine, every hospital and most offices use computers for billing and financial records. Computers are everywhere—or so it seems.

But computers are not in the doctors' examining rooms or at the hospital bedsides. Instead, with a few exceptions, we are still wed to that collection of handwritten notes, typed dictations, x-ray and laboratory reports, all stuffed into a folder or binder and stored in some cabinet or rack. Despite the incredible changes in medical care in the last 40 years, our charts are not much different from those in the 1950s.

Now with the growth of managed care, there is a tremendous demand for patient records. To attain the holy grail of "cost-effective care," HMOs of all persuasions are seeking access to our charts. But with a paper-based system, access is both expensive and time consuming. Every patient has a different record for every office and hospital he has visited. This multiplicity and dispersion makes assembling a complete record very difficult. And even then, someone has to laboriously extract the data from this pile of paper. The logistics are so overwhelming that task is essentially impossible. Given the new economic rules of today's health care, information is money. That information will soon come from the electronic medical record.

But the electronic record will also benefit physicians' delivery of care. It will always be accessible, no longer a paper chart "missing or unavailable" in the bowels of some record department. The attending physician will be able instantly to retrieve the record, and so will consultants, housestaff, and other authorized personnel, no matter their location. Complete medical histories, including laboratory, EKG, x-ray reports, and medication lists, will be accessed from hospital, office, even home. Quality of care will improve as important details, particularly allergy and medication histories, are not overlooked by consulting and covering physicians. Repetitive testing will be eliminated as results are available to all providers.

Electronic records will enhance preventive health services. Charts will be flagged to insure compliance with recommendations on cervical cytology, mammography, sigmoidoscopy, and the like. Such screens will be further customized by automatic cross referencing to individual risk factors such as age, personal and family history. In addition, the data can be studied for cost-effectiveness, for example, cholesterol or PSA measurements according to age or other variables.

Electronic charts will also improve the diagnosis and management of disease. Analysis of symptoms and physical findings, drawing on large databases, will alert the clinician to statistically-based altemative diagnoses and suggested testing. Physician-designed algorithms will suggest management strategies immediately relevant to the patient at hand and provide references to the pertinent medical literature. Alternate treatments for chronic disorders, such as diabetes, hypertension, and cancer, can be compared and evaluated. Subtle differences in

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treatment groups, currently undetectable in the relatively limited size of today's clinical trials, may become evident as larger patient populations are studied.

That's the good news. Unfortunately, there is bad news as well. First, an enormous capital investment will be required. To exploit fully the advantages of the electronic record, there must be multiple temminals available in every office and hospital, at all the locations where we now use a paper chart. Data entry and retrieval must be very quick, requiring hard-wired links to all community hospitals and doctors. The system must be fully compatible with the various data formats in use today, so that multiple providers, laboratories, and hospitals can download into a single record, and it must be adaptable to future enhancements. In an era of cost containment, who will finance this infrastructure?

Giving Payors Keys To Your Office

Second, there must be an "administrator," overseeing the network. The electronic record is useless if the system crashes. There must be around-the-clock supervision and fail-safe backup capabilities. Facilities for generating, updating, and storing a paper record must be available for emergencies and for provision of data to those outside the network. Who will control this administrator, physician, hospital, or insurer?

Third, physicians must be willing and able to use the electronic record. If data entry is delegated to clencal personnel, the accuracy and quality will be jeopardized. Therefore, time and effort must be expended to teach physicians how to enter, not just retneve, clinical informnation. This is the major barrier with today's software. The vast majority of clinicians predate the computer revolution; they cannot type, and they find mousing through menus tedious and slow. One of the unappreciated facts of computerization is that the speed comes with data retrieval and analysis, not with data entry. It is generally slower to enter data on a terminal than to scribble or dictate a note. The hope on the horizon is the development of practical and efficient voice recognition technology, but that is probably five to 10 years away.

Fourth, the pressure for an electronic record will come primarily from commercial and insurance interests. While the goal is to improve patient care, the subtext is to reduce costs. If they provide the necessary hardware and software, third parties will expect a retum on the investment. Payors could use our data to tell us what to charge and even how to practice. In effect, we will be giving them the keys to our offices. Do we wish to cede control of our records to those whose motives are other than improved patient care?

Finally, there are issues of patient privacy. Already patients abdicate confidentiality by blanket clauses in most insurance contracts. But the unavailability of the paper record has afforded them at least some measure of pnvacy. The electronic record can change that. As discussed in detail by Woodward (*N Engl J Med* 1995; 333:1419-22), this should be a concern to all. Medical conditions of a highly personal nature will be available to anyone who can access the system. Does your ophthalmologist need to know you've had an abortion, or your dentist that you once drank to excess? How about your insurance company, who in addition to medical coverage may be writing life or disability policies? Who will decide the levels of password protection and how secure will they be? Thus, the widespread availability of the electronic record, clearly its major benefit, is also its greatest liability.

Of all the developing changes in healthcare delivery, the evolution of the medical record is potentially the most far-reaching. It is, after all, the only tangible manifestation of the patient-physician relationship. As we transform our handwntten notes to electronic bytes, we must balance carefully the benefits of expanded information access with the loss of individual confidentiality. Public health will best be served by protecting our patients' pnvacy. ▼

P. John Seward, MD

The AMA's new EVP talks about his vision for the future.

American Medical Association

What is your vision for the AMA?

To continue to reinforce our role as the primary national advocate for patients and physicians. In the most fundamental way, that is what medicine is all about. And the AMA can act on behalf of millions of patients. We continue in a good position to do this. We are financially secure and programmatically sound. We are strongly positioned as medicine's leader, and I see us continuing in that role.

How has your background prepared you for your current role as EVP?

I was a practicing doctor, with all the joys, problems, hassles, and tears that practicing medicine brings. I've also been the manager of a number of successful business enterprises and a longtime public official. All of this and my service as member and chair of the AMA have given me enormous experience and perspective for assuming this new role.

Some physicians are reluctant to join the AMA because they don't believe it represents their interests. What will you do about that?

The AMA currently represents physicians' interests. We have represented physicians in Washington on issues of health system reform, Medicare and professional liability, we have led the charge in public health issues such as domestic violence and tobacco, and we are currently evaluating the Federation and how it can better serve the needs of physicians and their patients. If physicians don't believe we are representing their interests, then we have to look at how we are delivering our message. We need to articulate and communicate the value of membership in a better way.

More and more women and minorities are becoming physicians. What is their incentive to join the AMA?

These are physicians whose talents and dedication will make health care better for all of us. Their incentive to join is representation and a chance to be an active participant in the changes in medicine as we prepare for the 21st century. The AMA has more female physician members than any other medical professional organization. We have a woman chair, Nancy Dickey, MD, for the first time in AMA history. We have Palma Formica, MD, and Regina Benjamin, MD, on the Board. We are seeing an increase in membership among minorities and international medical graduates because the AMA is seen as a solution to the hassles that they are facing.

The Federation study suggests changes in representation from state, county, and specialty societies. Will these changes significantly affect membership?

The AMA is a dynamic organization. We have been changing for years. The Federation study is just part of that change. The purpose of the Federation study is to give practicing physicians input in how their societies make policy so that they do not feel shut out. I believe that membership will increase as a result of the study.

How will the AMA help doctors educate patients about changes in Medicare and Medicaid?

We will work with the media – sending our Board members to editorial boards and radio and TV stations across the country to broadcast our message. We will provide members with updates on all our Medicare activities as we implement them. As we have always done, we will listen to physician input about our policies and work with America's physicians to bring about the best in health care for patients.

Will the AMA continue public education and awareness programs on tobacco and domestic violence and other public health activities?

Definitely. Public education and public health have been major AMA activities since our founding 150 years ago. As a Florida newspaper editorial said, maybe we don't really need a US Surgeon General as long as the AMA is around. The AMA is a recognized voice in public health issues and we take that responsibility very seriously.

How will the AMA help physicians gain more control over their careers during this time of change in physician's practice environments?

By continuing to inform physicians about our actions in Washington, about the environment in which they practice and about the best ways in which they can take control of their medical practice.

What are the AMA's 1996 legislative and political goals?

We still will be concerned with the issues we pursued in 1995. Last year was very busy, legislatively. We staked our our territory and stuck to it: Medicare, liability reform, doing away with hassles like Stark I and Stark II, CLIA and patient protections. We made tremendous headway. That agenda is still as cogent for 1996 as it was for 1995. If anything, the need to accomplish it is even higher. Just getting close doesn't excite me much. Now we have to say "we can do it!"

You were the elected county coroner for 23 years. How did that prepare you for AMA leadership?

An old friend of mine taught me that good politics is good service, and good service is good politics. You had to earn their trust every day. It humbled me. It taught me to keep an open mind, Any time I jumped to conclusions, I was absolutely wrong. Team work is very important; you can't do it alone. I look at this job the same way. An EVP isn't supposed to be a hero. I anything, I would classify myself as a "designer" of bringing people together, helping inspire our team to do a better job.

How do you see the practice of medicine changing?

Medicine in some ways hasn't changed at all. It's still about providing the best care to individual patients. In other ways, it's changing hugely in what we can do for those patients. The cost of health care will continue to be a major issue. Anytime you upgrade, you create new concerns, specifically ethical ones. Will our ethics be able to keep up with how we apply technology to our practices? As professionals, we have to be leaders in this because it's our duty. The AMA has to help our physicians say, yes, we are still on course, but we are also advancing.

How will the AMA work to overcome the loss of collegiality and unite physicians in the future?

I'm an eternal optimist. Is collegiality irretrievably lost? I don't think so. As physicians, we all have so much in common – our devotion to medicine and to our patients, and the prob-

lems that affect us all in the practice of medicine. I'm confident that we have the motivation and the desire to work together. When you talk to physicians who are saddened, anxious and depressed, it doesn't matter what type of health care delivery system they're practicing in, they are still physicians. This is where the AMA can be the catalyst to redefine who and what we are. To show we all need to work together. This is a legacy issue. I want to make sure we leave the profession better off than what we found it. This is how I want to be measured.

How will your role differ from that of your predecessors?

I'm different and the times are different. The information age has brought everybody closer. When somebody sneezes in Seoul, Korea, it affects me in Rockford, Illinois. It's the same medicine. The AMA must continue to be better focused, more receptive, more efficient. We do not have the luxury of contemplation and inaction. We have to be faster on our feet.

What about Medicare reform?

The AMA is committed to transforming Medicare. We'll stay the course. The proposals we gave to Congress are still on the agenda. Patient choice. Quality of care. Physician-sponsored networks. Patient protection, medical liability, reform, relief from Stark I and Stark II, CLIA.

What about Medicaid Reform?

We want to make sure this vulnerable group receives adequate and appropriate care. They're patients. They're also family, neighbors, and friends. Standards have to be maintained to make sure that they do obtain care, whether it's by "block grants" or some other mechanism. We also have to consider long term care. One this and so many other critical issues, the AMA has to be a watchdog. We have to help define the road the country needs to take if all our patients are to get the care they need. ▼

The Hippocratic Legacy

Reviewed by David W. Hodo, M.D.

***Hippocrates in a World of Pagans and Christians*. Owsei Temkin. The Johns Hopkins University Press: Baltimore and London. 1991. 256 pages.**

Hippocrates in a World of Pagans and Christians is a timely book. Hippocrates is regarded as the father of medicine, some would say even the discoverer, the inventor, the synthesizer of modern medicine. Alas, his preeminence has been recently lessened as economics has replaced altruism.

Hippocrates is a physician not easily discarded, as this book clearly demonstrates. Neither the political tides of his day, nor subsequent ones in the-centuries that followed, dislodged the compelling teachings of Hippocrates. Indeed, Greek-Hellenistic medicine dominated medical thought. The other great physician of antiquity, Galen, also a Greek, espoused and expanded the work of Hippocrates. "Galen claimed that Hippocrates, like himself and a few others of the ancients, practiced medicine for the sake of philanthropy." They were the giants of medicine.

Dr. Temkin skillfully traces these teachings and the Oath of Hippocrates's integration into an increasingly Christian world, into other religious beliefs, "in the Orient and Occident," from its pagan beginnings. Hippocrates brought medicine to all. "Whereas the arts and sciences were mainly a matter for the educated, medicine was part of everyday life in all levels of society." He demanded respect for life including "specific prohibition of any involvement in murder, suicide, and abortion," which was also in keeping with ethical Christian standards. It is noteworthy that recent judicial decisions in the United States have reversed Hippocrates.

His call is to hardship. Hippocrates is quoted as saying, "The physician sees terrible things, touches what is loathsome, and from others misfortunes harvests troubles of his own". The writings of Galen indicated that "Whoever wished to emulate Hippocrates must not only despise money, he must also be extremely industrious, and therefore must avoid drunkeness, gluttony, and lechery." Galen wrote, "The true physician must prove to be a friend of moderation and a comrade of truth." Hippocrates's contempt for money also dovetailed with Christian beliefs. Dr. Temkin summarizes Hippocrates as seeing "the lust for money as a madness for the cure of which all doctors should unite." "Hippocratic doctors did not consider whether their patients were good or evil." How starkly this image contrasts with modern transformation of physicians and patients into providers and participants.

Dr. Temkin's book is remarkable in every way. He writes joyful prose, sparse, organized, and concise. A subject some might consider heavy reads more like a spirited novel. I found myself eagerly anticipating the ending and was not disappointed.

Dr. Temkin's career at Johns Hopkins was extraordinary. He is William H. Welch Professor Emeritus of the History of Medicine at Johns Hopkins. He exemplifies excellence in medicine. He, his colleague, Dr. Ludwig Edelstein, who died in 1965, and many others past and present are modern keepers of the Hippocratic flame. He elucidates the wisdom of Hippocrates and medicine's need of his teachings. Hippocrates was driven to discovery by the low state of medicine in his day. Dr. Temkin gently (or perhaps not so gently) chides us to note the vacuum created when honor, altruism, phil-

antropy, and devotion to life go out of the heart of medicine. I recently spoke with Dr. Temkin. Now in his nineties and retired, he remains formidable. I had called him a couple of years ago to inquire about his and his wife's edited collection of the writings of his friend, Dr. Edelstein. He was gracious but told me not to ask questions I could learn from reading his book. It was a heart warming reminder of what medicine and teaching can be, a demand for excellence.

Dr. Temkin closes his book by challenging us to be good Samaritans. He inquires, "What would a modern doctor do, mindful of the Hippocratic Oath and of ethical codes but also aware that his assistance might be requited by a malpractice suit?" He concludes, "Throughout the world of pagans and Christians, Hippocrates represented the autonomy of medicine as a sphere of life. With this system and many of its practices discarded, he has yet not ceased to do so." The spirit lives. Thank you, Hippocrates. Thank you, Dr. Temkin.

David W. Hodo, M.D.
Selma, Alabama

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Information Technologies in Healthcare

by Ronald B. Davis, M.D.
*In Kansas Medicine**

Healthcare is fertile ground for information technologies. There are tremendous amounts of money in this industry; in fact, the U.S. economy in healthcare is more than the gross domestic product of all but a few countries. Thus, the demand on the "center of the universe" of healthcare, the medical record, is tremendous and growing rapidly. Paper systems can no longer adequately meet the demand.

We now look to computer systems (hardware and software) for answers to these information needs. Hardware is scientific, structured and rigorous, and is developing rapidly. Software design is artistic and abstract and facilitates most of the interface between computer and user. Together they continually increase their presence in the processes we use.

Will adaptive neural networks establish protocols?

There are several software approaches to information management, each with strengths and weaknesses. They include text processing, spreadsheet, database, knowledge base and neural network. Text processing has rich expression capabilities but doesn't handle large amounts of information well and is not amenable to queries. Databases handle large amounts of information efficiently, but lack the ability to provide a tailored medical record. Knowledge-based systems provide pre-processing. As symptoms and findings are recorded, the knowledge system narrows the differential diagnosis list. Adaptive neural networks (able to learn from physician patient encounters and predict the protocol for the optimal outcome) are in their early infancy, but as these mature they will change the character of medical practice more than any previous evolutionary event. This will be the true future shock—surpassing the profound effect of managed care on the medical community. Two variables are interdependent: "human ware" and information technology. Humans have always strived for new and better ways of doing things, yet have resisted their implementation at the "front line." We don't like change. Yet change will occur in healthcare as physicians assimilate new ways of doing things and as technology becomes friendlier, more transparent and embedded in the processes we use.

Making Data Available

As information technology develops and is implemented, there will be increased quality with decreased cost of healthcare. An area of importance to us all is data capture. Keyboard input is inefficient, error-prone and time-consuming. Light pen, stylus, handwriting recognition, and voice recognition are developing methods of handling data capture efficiently. Improvements will be seen in adjacency, the time between data generation (i.e., physical examination) and data capture (i.e., recording of findings). This will result in a more complete and accurate medical record. The information

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also will be available sooner to others with the right and need to know it. To ensure maximum value from this medical record, connectivity is crucial.

Connectivity (availability of medical information to anyone who has the right and need to know) is a formidable and important barrier to efficient information management. There are different computer software operating systems, various computer hardware systems, incompatible applications software, and limited networking. There will be "survival of the fittest" in data interchange technology and standards. The most effective and efficient driving force for this will be informed and educated consumers, demanding high connectivity. This will be very important to managed care organizations, which work with populations rather than individuals, and they likely will lead the thrust for greater connectivity. As connectivity is improved another hurdle arises: how to display all this information in a meaningful way.

High connectivity results in tremendous amounts of information. How can it be managed? What are the goals of this management?

Complicating this issue is the diffuse nature of a patient's health information. It is literally more than a lifetime long. Multiple providers are involved. Multiple facilities are used to consume healthcare. Powerfill and sophisticated computer systems will be needed to keep complete records. Once data capture and connectivity are solved, the greatest challenge will be pre-processing and processing of data.

Pre-processing and processing will metamorphose data to information, information to knowledge, knowledge to disease management planning, then to disease prevention. Expert systems and neural networks will be involved in this transition.

Using Technology Wisely

Each advance in technology gives us something, but it also takes something. We should ask questions when a new technology arrives. What are the ethical issues? What are the side effects? What will be the unintended consequences?

Maintaining the patient's best interest as the central theme during this infusion of information technology into our profession may be a daunting task. Maintaining our professionalism may also be challenging. Practicing physicians must take the leadership role in harnessing this medical information revolution. We must implement information technologies to serve the patient, not the system.▼

Pricing your Practice

What you don't know can hurt you

by Larry BeSaw, Associate Editor and Sharon Carter
*In Texas Medicine**

If someone walked into your office this afternoon and offered to buy your practice, would you know how much to charge him if you decided to sell? The chances are good you wouldn't. But don't feel too bad, because you are not alone. Health-care consultants say most physicians simply don't know the value of their practices, primarily because until recently they didn't have to know.

"The market didn't demand it," explained Reed Tinsley, CPA, of O'Neal, McGinness and Tinsley in Houston. "It was a very complacent market, but in the last 2 years it changed quite a bit. It's gotten very competitive because of managed care."

Doug McSwane, of McSwane and Associates in Richardson, says most physicians tend to undervalue their practices. "Keeping in mind that everyone you are thinking of selling to has a vested interest in keeping the figure as low as possible, you really need to know what it is worth. It is just good business to have your practice evaluated by someone who has no ax to grind in the matter," he said.

There are several reasons why you need to know the value of your practice. A hospital, hospital-related physician organization, or a large group practice may make you an offer. Maybe you're thinking of taking in a partner Perhaps a divorce is looming. You may be looking ahead to retirement, seeking bank financing, or planning to move to another part of the country. An evaluation has a second benefit. The study of a practice can give you an overview of business operations that can help to spot and fix problems you may not even know existed. Correcting these problems can significantly increase the worth of a practice.

A good deal?

As Texas hospitals, specialists, insurance companies, and entrepreneurs seek to lock in their primary care bases, the creation of integrated delivery systems and physicians' worries about how they will affect them have dramatically increased the sale of medical practices. But experts caution that before you sell your practice, you must decide if it is really necessary. In many cases, it is not.

"I think doctors are selling out way too quickly, and I think it's based on misplaced fear," Mr. Tinsley said. Increased competition, changes in reimbursement, and the growth of managed care and capitation are "just scaring them to death and they're selling out. They need to think twice about it." Younger physicians, especially, are selling their practices prematurely, he says.

Mr. Tinsley says that although the fear of losing income is often the motivation for physicians to sell, he has been able to identify only three areas where he believes physicians' collections could decrease:

- ***Reimbursement.*** "Reimbursement is going to go down. We know that. But do you have to sell out? There are alot of alternatives to maintain a doctor's bottom line without selling out and losing all of that independence."
- ***Competition.*** "What is going to happen in your service area where competition is going to come in and take patients away from you?"
- ***Denied access.*** "What could happen in the next 3 to 5 years if a patient cannot call up and make an appointment with you, or a doctor cannot refer a patient to you? The

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two ways that's going to happen under the denied access theory is deselection from a preferred provider organization or capitation."

Mr. Tinsley says physicians must answer those three questions before deciding to sell their practices. And if you do decide to sell, Mr. Tinsley adds, make sure you understand what your relationship with the buyer will be. "Too often, doctors just look at the purchase price and not the relationship they are going to have with that entity for the next 5 or 10 years. You need to look at what your compensation is going to be, how it can change, how you can get fired—all the little stuff that you would normally go over when you become employed by somebody. A lot of people aren't looking at that right now."

You must also make sure you understand how the sale will affect the way you practice medicine. "These people who are buying practices need to make a profit. At some point in time, there's going to be pressure put on that doctor to generate revenue. You can't just fork over $400,000 to a doctor and say, 'OK, now do what you want to do.' Maybe you're seeing 18 patients a day, and they say you have to work Saturday mornings and you have to see 28 patients a day," Mr. Tinsley said.

Adding it up

How do the experts determine the value of a physician's practice? There are many factors to be taken into account, and no two practices are alike, Mr. McSwane says. "Even practices that look very alike on the outside can stack up totally differently when put under the microscope."

A medical practice evaluation begins with any real estate the practice might own. If property is leased, the appraiser should compare rental rates with those found in the market for comparable property. Terms of the lease matter, also. If you are in solo practice, check whether your lease includes a clause that allows you or your executor to sublet without a rent increase. What improvements have you made in leased property? Freehold lease improvements are often overlooked. Improvements made in leased property such as special lighting, air conditioning, and interior construction of offices and examinations rooms raise the value.

"When I evaluate a practice, I begin with the tangible assets, which will be everything from plastic waste baskets to large equipment, like x-ray machines, a CT scanner, or an MRI," Mr. McSwane said. "In equipment such as that, age is a factor in the value, and so is whether the equipment has been replaced with new and better technology."

The value of medical books and journals is considered, as are pharmacy and medical supplies such as xray film. This value is usually based on an average monthly cost with a 2- to 3-month inventory.

The type of practice makes a difference. Generally speaking, a family practice used to be somewhat less valuable than other specialties, but this is rapidly changing because of managed care.

Location is a definite factor to be taken into account. A urology practice is worth more in a community with a high percentage of retirees than in a college town. A retirement haven is less hospitable, and less profitable, for a pediatrics practice than is a suburban community of young families.

Accessibility may also matter. An ophthalmologist, for example, will have a higher-than-average percentage of patients who cannot drive, so public transportation that drops them off at the front door is a plus.

So is good parking. Parking right outside the door, rather than across the street or down the block or where patients have to pay to park, increases the value of the practice. This is particularly true if a large percentage of patients have trouble getting around, such as the elderly, orthopedics patients, or young mothers shepherding small children.

Mr. McSwane says that once the study of assets is completed, he examines the practice's fixed assets, usually for the previous 3 years, to determine trends. Is the practice growing or shrinking? If it has remained stable, are a high percentage of patients getting into the

Medicare category? If so, what is being done to bring in new and younger patients?

He considers the referral base. "Are there a lot of doctors referring patients to you? And if you need to refer your patients on to specialists, or specialists in other fields, are these available? How much is transferrable?" If a doctor has died, the referral base all but evaporates. But a doctor buying into an existing practice should reap the benefits from the referral base already there.

And, do not overlook the value of goodwill and your reputation in the community. Word of mouth is the best advertising a doctor can have, and satisfied patients who tell their friends are worth a great deal.

Buyer beware

What if you are the physician buying into a practice? Knowing the various factors that can affect its value is important, especially if the new practice is in a new town.

One of those factors is competition. Obviously, a pediatrics practice with four or five other pediatricians in the immediate area is worth less than a practice where the doctor or doctors are the only pediatricians in town.

"You should also keep competition in mind if you are buying a practice where the doctor is leaving. There needs to be an agreement that he won't, for example, be retiring early and moving to California, and then decide he doesn't like being retired and hates California, so he moves back home and opens a practice just down the block in competition with you," Mr. McSwane said.

The economics of the locale are important, too. A community with a solid, varied economic base is one thing, but a community whose main employer is a military installation, with rumors that it will be closed floating around every time Congress is in session, is another.

The availability of hospitals and other medical facilities matters. Are the proper facilities available if a patient needs to be hospitalized immediately, or needs specialized lab work or an MRI?

Because managed care is rapidly becoming a significant factor in the value of most practices, even in rural areas, the penetration of managed care into the area must be considered. Texas Medical Association General Counsel Donald P. Wilcox, JD, says physicians moving to new towns must consider whether the dominant managed care players will be willing to contract with them and whether their contracts will be reasonable.

Finally, you'll want to review the business policies and operations of the practice. If you are buying into a practice that in the past has let a lot of debts slide, you need to reach a mutual agreement with your new partners about how this will be handled in the future. Otherwise, it could become a very sore point.

Now and later

A business analysis gives what amounts to an x-ray of a practice. And that can be of great value whether you're considering selling or not. "A lot of doctors are too busy practicing medicine to have time to properly manage the business part of their practices," Mr. McSwane said. "An evaluation can turn up some surprises in that regard." You might find that you are seeing more patients but somehow not generating more, or even as much, income. Sloppy bookkeeping or inaccurate billing could come to light. Some physicians have been surprised to find the amount of accounts receivable not collected, simply because the unpleasant tasks of calling people for money is not delegated to any one person and no one volunteers for the role. The overview can lead to a realization that the business operation needs some changes. Implementing effective management procedures can increase the value of your practice, if and when you decide to sell. ▼

Medicine Does Not Exist in a Vacuum

*David A. McLain, M.D., FACP, FACR**

The conventional wisdom of the day envisions medicine being revolutionized with the elimination of specialists, consolidation of providers, and continuation of high quality service at cut rate prices with a resulting decline in physician incomes. Conventional wisdom is not always correct. With the advent of movies on videotape in video stores the prediction was that movie theaters would close. For a time, movie theaters were being sold at discount prices. Now, movie theaters are thriving and videotape technology is being challenged by satellite and other technologies. With the advent of computers, a paperless society was predicted. We all know that this has not come to pass. Moreover, computer use itself generates hardcopy output. Certain principles that apply to life outside of medicine suggest today's conventional wisdom portraying the dismal future of medicine may also be false.

Conventional wisdom dictates that there are too many specialists in medicine. The principle in real life is that there are specialists in many trades and learned professions. We recently remodeled a room in our house. We had a general contractor (our primary care person). But the general contractor brought in a plumber, an electrician, framing carpenters, trim carpenters, a sheet rock man, a stone man, a cabinet maker, a painter, a wallpaper hanger, a telephone man, a heating and air conditioning specialist, a decorator, a security alarm specialist, and an intercom specialist. Fourteen specialists to remodel one room! And the building trades are a lot less complicated than medicine with its rapidly expanding fund of knowledge.

In law, diversification is also the rule. There are specialists in each area of the law including corporate, tax, trust, criminal, social security disability, personal injury, bankruptcy, union, insurance, governmental affairs, legislative lobbying, securities, banking, toxic waste, medical malpractice, product liability, workmen's compensation, oil and gas, railroad, divorce, civil rights, equal opportunity, maritime, and real estate to name a few. Even in the specialty of real estate law there are subspecialists. There are lawyers that specialize in real estate closings and others that specialize in zoning disputes. In architecture there are specialists in homes, churches, schools, restaurants, shopping centers, office buildings, medical facilities, public buildings, office towers, service stations, golf courses, and many others. The same is true for specialization in dentistry and accounting.

Specialization in medicine is not an anomaly. It was not developed in order to increase reimbursement. Medicine should not be ashamed or feel guilty for specialization. Rather, it is a natural outgrowth of the explosion in knowledge that has occurred in many fields. If a "jack of all trades" was the general standard of the community, then specialization would not be utilized in many other professions and trades. This is not to diminish the important role that the good generalist in medicine plays in his or her community. A well informed generalist who is aware of his or her knowledge and limitations is a great resource for their community. These generalists should

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not feel guilty or financially deprived in consulting a specialist when one is needed. A recent medical malpractice case reported on national television reported the asphyxiation of a young girl by a foreign body. A pulmonologist was called to the ER who attempted a retrieval of the foreign body. The hospital emergency room was faulted for not transferring the girl (who subsequently died) to a neighboring ER where a pediatric pulmonologist was on staff who was familiar with removal of foreign bodies in children. Specialization is not only the standard but a necessity in the community and the public demands it.

A second principle in the community is that services are expensive and can't be compared with the mass marketing of products. While conventional wisdom speaks of "K-Mart Medicine," there is a big difference between the mass merchandising of products (many imported from low wage third world countries) and the mass merchandising of services. Mass merchandising of eye glasses and pharmaceutical services has occurred but products are involved in both and the production of both can be partially mechanized. However, bigger is not always better. A pharmacist recently told me that in his community a large employer went to an "800 number pharmacy." Instead of their pharmacy costs decreasing, they actually increased by 25%. The local pharmacists' lower cost may be attributed to face-to-face counseling and dispensing smaller amounts. Hair salons and tax preparers (e.g., H & R Block) also have national and regional chains which have helped to lower prices by giving an economy of scale. However, in the vast majority of cases, these national chains are not presumed to be the highest quality providers in their field.

While products can be mass produced to lower cost, this is not possible with personal services. Services are expensive. A fifteen minute hair cut can easily run $15. Electricians and plumbers charge around $50 and $65 per hour respectively. Architects, lawyers, and accountants are more expensive than this. Personal services are delivered to one client, customer, or patient at a time, each requiring individual attention to detail. The cost of the service provided takes into consideration both the time required to provide the service as well as the training required for the person to be able to deliver the service. Services usually cannot be self administered, whereas self administration has become the rule with modern discount shopping.

A third principle in the community is that time is money. With all services, time is the product that you are selling. In law, architecture, and accounting, phone calls constitute a considerable source of income. Traditionally, in medicine, all phone calls are free whether to the physician's office or through the answering service after hours even though work is being done. A large percentage of medical service is dispensed gratis over the phone. My office easily receives over 40 phone calls a day. The income from this service would be a good revenue stream for an attorney. With physician reimbursement continually being racheted down, the traditional practice of dispensing care by phone for free [or considering the call as included within the last discounted fee for service visit (perhaps several years old)] no longer seems reasonable or fair.

A fourth principle in the community is that the service level is higher when the profit is higher. When you go to a fast food restaurant, you order at the counter and carry your food to a table that you find for yourself. You are responsible for finding your own condiments, napkins, and tableware. You may even clean up after yourself when you have finished. Contrast this to the elegant restaurant where you are shown to your table, have the napkin placed in your lap, and have your glass filled after each sip of water. You receive solicitous service throughout the entire meal. The difference between the two restaurants, besides the

quality of the food, is the profit margin per customer. As the profit margin increases, so does the service level.

The public is accustomed to high quality service in medicine unless they must go to the military, VA, or public health clinics where people might be "herded" through. As profit margins drop in medicine, the service level must also drop. It is a principle that naturally exists in the community. We have all seen the level of service in our hospitals decline as reimbursement has been cut and profit margins drop. From the use of lightly trained aides and patient care technicians, to formularies, to "drive through deliveries," current medical care is in marked contrast to the old days. How much further can profit levels fall before military/public hospital service levels are necessary?

A fifth principle in the community is that utilization costs money. We see this with our utility bills and mortgage costs as well as the costs of food, transportation, clothing, leisure, and education. In medicine, the majority of the utilization is unpredictable and as a result, insurance companies evolved to disperse the risk of an illness or injury among a number of individuals. One new trend in medicine is to have the physician serve as the risk taker by accepting a capitated payment which is unrelated to utilization for a specific number of covered lives . This trend is leading to consolidation as individual physicians or even small groups of physicians are unable to accept the risk. For an insurance company or other entity to skim off a percentage of the profit without accepting any risk is a dream come true. This trend may lead to the elimination of the middle man so that providers contract directly with employers and patients. The fact remains that utilization does cost money and if capitation does not at least cover the costs, it will not succeed.

A sixth principle in the community is that there is a labor market that sets wage levels and no one works for free (except for altruistic motives). Considering that the cost of medical education is on the rise, the number of years of training following high school exceeds ten (13 years in my case), and that physician salaries are declining, a time will soon come when students entering college will not consider medicine to be an economically viable career. With medical student loans not uncommonly over $50,000 and with internship, residency, and specialty training resulting in many years of low salary, other careers with higher, less controlled wage levels will seem more inviting. As the number of people entering medicine drop and as older physicians frustrated with the changes retire, those physicians remaining will be in higher demand.

As the pendulum swings in medicine to where it appears that there will be less opportunity, less reimbursement, and less freedom, our saving grace is that medicine does not exist in a vacuum. The real world of economics will only allow the pendulum to swing so far. ▼

Preserve Patient Privacy

*by M.J. Fitz-Gerald, M.D.**

Over the past few years, one of the biggest gripes that I have heard from patients is that "the doctor is more interested in my money that he is in treating me." One place that this seed gets planted is possibly in our front offices.

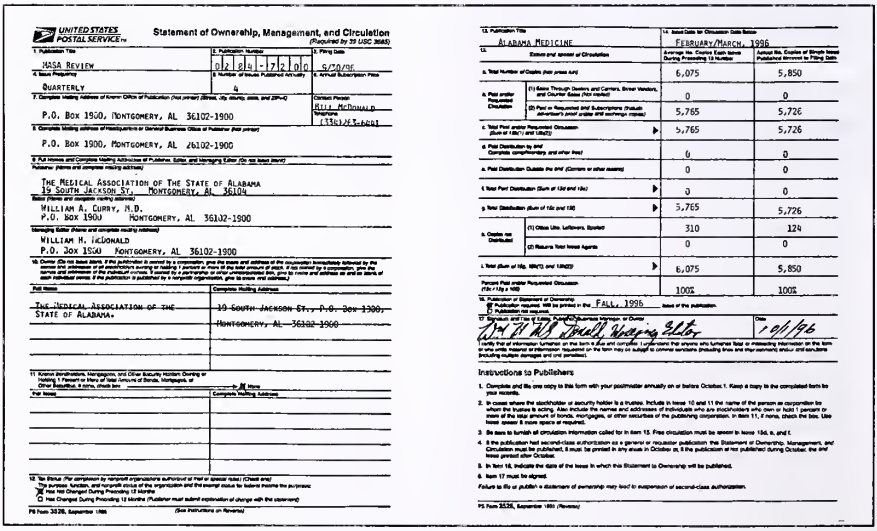
When a patient comes in, he is sick, he is apprehensive about his condition; the last thing that he is interested in talking about is money. Also it is usually quite embarrassing for people to have to discuss whether they have insurance or if they do not have insurance, with a waiting room full of people. Well, how can we get by this problem?, because we certainly have bills that we have to pay.

I would like to pass an idea along that we have incorporated into our clinic that you might find helpful.

We have a reception area staffed by two women and it is their job to make appointments and sign patients in, pull their charts, etc. But these two women are in no way responsible for payment, insurance, etc. You are not going to refuse seeing a sick person, so why not let's just get the patient in, see him and take care of him and then after his fears are alleviated and he knows that he is not going to die or lose his arm or whatever, bring him to (what we call) "Patient Relations." This is a little area that is quiet and private. Have the patient sit down with somebody who is knowledgeable in insurance, payment, etc., and work out how the patient wishes to handle the bill that he has just incurred.

We have found this to work extremely well in our office and many patients have commented to us how much of an improvement like this is over having the receptionist in the front into all the billing, etc.

*Demopolis, Alabama.



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Information may rule the roost

by Greg Borzo
in American Medical News

Five years ago, physicians couldn't find the enter key on a keyboard; now they want to do their gallbladder surgeries from home.

A slight exaggeration, perhaps, but that's how Richard S. Abrams, MD, sums up the progress physicians have made adapting to the wealth of new computer-based information tools and technologies.

The medical director of clinical information at Rose Medical Center in Denver spoke at the Health Care Information and Management Systems Society annual conference recently.

Until recently, medicine has been immune from the information revolution sweeping other industries.

Airlines, for example, have long survived on information and the strength of their computerized reservation systems. Those that landed on the block as that industry consolidated typically fetched more for their information systems than for their fleets. Meanwhile, the *Official Airline Guides*, a monthly guide to air travel, flight schedules and itineraries and lodging information, has been more profitable than most airlines for the past several years.

Now, information systems are taking center stage in health care, too. Not only do they cut costs, but they also promise to help improve the quality of care and outcomes research.

"The information that physicians generate in the course of their work can be more valuable than the treatments they administer," said Arthur Keegan, vice president at HBO & Co. in Atlanta. "Today, knowing who has diabetes or cardiovascular disease and how to keep them healthy is far more valuable than owning hospitals or MRIs."

Here's a sampling of what other HIMSS speakers had to say about the information revolution.

Physicians' changing role

• The shift to clinical information systems isn't at all about learning how to use computers. Rather, it's about learning new ways to measure our performance, keep up to date, interact with colleagues and relate to patients—in short, a whole new way of practicing medicine.

—William Stead, MD, professor of medicine at Vanderbilt University.

• Years ago, I had to turn the pages for some doctors as they read their medical records. In the near future, computers will put all the information physicians need at their fingertips.

—Chris Thorne, director of health information management at Washoe Medical Center in Washoe, Nev.

• Physicians are the fastest-growing category of health care CEOs.

— Mark S. Gross, vice president, First Consulting Group in Mt. Laurel, N.J.

• If physicians circle the wagons in the face of emerging health care information systems, we risk becoming marginalized.

—Peter B. Campbell, MD, physician at Hurley Medical Center in Hurley, Mich.

• Electronic records will improve rather than diminish the security of health-related data. Today, scores of people have access to medical information at dozens of points along the continuum of coverage, care, payment and

review. Computers give us the power to control, reduce and monitor that access.

— Pamela Wear, vice president at Innovative Health Systems in Sacramento, Calif.

When negotiating for health care services, payers often have more information about a hospital's performance— right down to specific physicians—than the hospitals itself has. But I keep telling providers that we, as payers, don't want to have to generate performance information on them. For the most part, we have access only to claims data. Only providers can generate fair, accurate, clinically oriented performance reports.

—Kenneth W. Gary, manager of compensation and benefits at Georgia Power Co. in Atlanta.

• Medicine has always been shrouded secrecy, but managed care companies and integrated delivery systems are making it transparent as they study every step in the process. Thanks to new computer-based technologies, we're learning that health care is a describable, repeatable and improvable process.

And make no mistake about it: Such information will be disseminated to the public.

Author Keegan, vice president, HBO & Co, Atlanta. ▼

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Earning CME Credit Online

by Fred D. Baldwin
*In Pennsylvania Medicine**

Online "chat" sessions aren't just for singles in cyberspace. An imaginative pair of medical professionals, who've never met each other in person, are pioneering an online seminar in which physicians earn Category I CME credits. It's perhaps the most innovative of several ways you can use a personal computer for continuing medical education.

It's nice to be able to do this in your home environment and still be able to interact with other physicians around the country." says Jeff Henry, MD, of Marion, Kansas. 'We can sit down and talk without having to get dressed up or paying a whole lot of money."

Dr. Henry is talking about a continuing medical education (CME) course he's taking online through America Online (AOL), currently the largest of the major commercial online service providers. This course is offered in a live, interactive format that seems to be unique so far, although it's only one of a growing number of ways to get CME credits using a modem equipped computer.

The course in question is called the Medical Studies Seminar, normally available every Wednesday at 9:45 p.m. ET. Participants receive one hour of Category I CME credit through Southern Illinois University Medical School for every seminar attended. The cost for enrollment is $10. (That's not $10 per credit hour, but the total tuition cost for up to 30 hours of CME credit. Participation requires a subscription to AOL, whose base rate is $9.95 per month. In some rural areas, connections to AOL may also involve long-distance charges.)

The Medical Studies Seminar grew out of an online friendship between Dariush Saghafi, MD, a young physician currently in a neurology training program with a hospital affiliated with Case Western Reserve School of Medicine, Cleveland, and John Faulkner, a physician assistant in Rocky Mount, North Carolina. The two, who have never met face to face, discovered common interests while participating in a medical "chat" group on AOL about three years ago.

Online chat groups are roundtable discussions in which all participants are logged on simultaneously; in effect, it's a conference call during which individuals communicate by typed messages rather than by voice. This simultaneous interaction differentiates chat groups from exchanges of information in a bulletin-board mode in which messages are posted for downloading whenever a reader logs on. Although interactive discussions require scheduling, they offer the advantages of spontaneity and immediate response to questions or comments.

Dr. Saghafi says that his and Faulkner's chat-mode participation in an AOL medical section led to a discovery of common interests and a desire to explore online education options. Among other things, both men were impressed by the quality of comments and suggestions made by participating physicians.

"The leading authority in some area would pop in and give us insight on some brand new stuff," Faulkner recalls. "We thought, this is such a benefit to all of us that there should be some way to get some educational credit. We investigated, and people said nobody was doing live interactive chats online when a guest speaker would present a case."

Dr. Saghafi remembered having seen a series of programs on Medical News Network called "Diagnostic Dilemmas," and he secured permission to adapt them for online presentation by visiting specialists. He then approached

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Southern Illinois University about supporting CME in an innovative way and received an "enthusiastic" response. The series opened for credit in 1995 and will continue throughout much of 1996. Participants seeking CME credit must register in advance with Southern Illinois University, but anyone can "lurk." ("Lurking" means reading public comments during a chat session without actively participating. It's not a pejorative term among online aficionados.)

All presentations follow a grand rounds format. "You sit in front of your computer," Faulkner explains. "You connect to America Online. You are asked to sign in. When asked if you want credit, you just say 'hello' or 'for credit.' That way we know who's there at the beginning. We introduce the speaker, who presents a case. For example 'A 40year-old white female who comes to the office complaining of shortness of breath...,' followed by a detailed introduction to her case."

From time to time, the presenters ask a multiple-choice question. Everyone taking the course for credit must transmit an answer to the session moderator.

"It doesn't matter whether they get it right or not," Faulkner says. "If they answer, we know they're still there. AOL has something called 'instant messages.' That means, if I want to say something to someone and don't want everyone to see, I can send it directly to him. We have everybody send an 'instant message' to me, and that way we know who's still there and who's fallen asleep at the keyboard. We have a little question-and-answer session at the end."

So far, seminars have proceeded without glitches. The only serious technological limitation is the impracticality of accompanying presentations with graphics—based on slides, CAT scans, and x-rays—that show patients' physical conditions. Digital reproduction of graphics involves enormous quantities of data, whose real-time transmission and downloading by participating physicians who use modems operating at varying speeds would take too much time during lectures. Dr. Saghafi notes that he and Faulkner are working on this problem.

In the short run, seminar participants may be asked to log on early to download a few key images before the grand rounds begin. In the long run, fully illustrated lectures will become practical as more transmission bandwidth becomes common.

Typically, between 15 and 20 physicians participate for credit each week. Only active participation earns CME credit, but anyone can download seminar transcripts from the service's library.

Could success spoil the Medical Studies Seminar? What would happen, for example, if a thousand physicians wanted to participate?

"America Online has a way of dealing with that," Faulkner says. "They put people in 'rows,' and you can only communicate with people in your row. You could have 5000 people if you wanted to. They [AOL] have had the president and famous rock and roll stars, so they've coped with a lot of people before."

Dr. Saghafi and Faulkner also sponsor a kind of medical trivia quiz game online (with a mix of easy and difficult questions) at 10 p.m. ET Sundays. Participants must answer within 10 seconds, and the evening's winners get free hours of connect time on AOL.

Faulkner notes that the level of sophistication among participants is high. Because AOL (like its major competitors, CompuServe and Prodigy) has a national membership numbering in the millions, its potential pool of expertise is comparable to that within a major metropolitan area—indeed, within one whose population has an above-average level of education.

He adds that a JAMA Journal Club is in the works for 1996, for which the American Medical Association has agreed to grant Category I CME credit to active participants. The expected time commitment is 90 minutes per month for six months. Physicians who do not wish CME credit may also participate.

Although the Medical Studies Seminar appears to be the only interactive CME course offered online so far, medical education sites are beginning to multiply on the World Wide Web. Medically oriented "Web pages," often

containing striking graphics, are spreading too fast for anyone to count accurately. Since Web pages are searchable online through several different approaches, the best way to locate options is to log on and poke around.

For example, consider the "Interactive Patient," a step-by-step problem session offered online by Marshall University School of Medicine, Huntington, West Virginia. The patient's painful symptoms and tests results lead to choices among 28 possible diagnoses and 21 possible treatments. Physicians with an Internet connection and a Web browser can examine the Interactive Patient at *http://musom.marshall.edu.* Registration for a $15 fee and a correct diagnosis earns 1 hour of Category I CME credit.

"This is a cost-effective way of doing things," Dr. Saghafi comments. "From the point of view of the institution that wants to offer CME credit, you cut your overhead in terms of meeting rooms, dinners, or whatever."

Dr. Saghafi contends that online sessions in the interactive format he and Faulkner are pioneering are "a little more intimate" than "going to a large symposium where you generally don't know many of the people." He acknowledges that "intimate" is not a word most physicians associate with computers. He also suggests that online chat sessions soon change technophobic stereotypes.

"It doesn't take very long to get used to it," he says. "You get almost a feel as if you were in a live session with everyone physically there. The screen names begin to develop their own personalities. The interaction and dynamics are as if there were about 10 people in the room with you. For example, I've never met John Faulkner at all, and I've never even seen a picture of him. But I can certainly sketch you his personality."

Dr. Henry agrees. Marion, where he practices, is a small town with a population of only about 2,500 and with a 20-bed hospital. "It's just nice," he says, "not have to make a special trip and still be able to interact with the other physicians around the county. It's almost a group therapy type of situation, too. Everybody has the same kind of problems. We can sit down and talk without having to get dressed up or paying a whole lot of money. One person chimed in at one point about how much they enjoyed sitting at home listening to Mozart and drinking sparkling water, or something like that, while participating in a CME course."

For further information about CME online, contact Dr. Saghafi at DrD@aol.com or Faulkner at faulkner@aol.com. ▼

Interview With Uwe Reinhardt

by Steve Adubato
*In New Jersey Medicine**

Uwe Reinhardt is the James Madison professor of political economy and professor of economics and public affairs at Princeton University. One of the nation's leading health policy experts, Professor Reinhardt is past-president of the Association of Health Services Research, on whose board he still serves. He currently is serving his third three year appointment to the Physician Poyment Review Commission, established in 1986.

Q. You have said that countries like Canada and Germany provide a civilized environment for health care. Do we not have a civilized environment in this country?

A. No, I don't think we have a very civilized health system. It's pretty good as far as the clinical quality goes. It's not the delivery system that's bad. It's the insurance system that is chaotic and unreliable; in Canada, it would be unthinkable to tell someone who is chronically ill that we will not insure you.

Q. But do you believe that most Americans really want egalitarian health care?

A. No, I don't believe so. That's okay, but once you have said that you have to develop a health plan tailored h the ethic you prefer. For example, you could say that we want a minimum floor for everyone. We obviously don't want people dying in the streets, but we don't care if everyone has preventive care. Essenhally, we are saying that now, but we should be more honest about it.

Q. In the end, is this why the Clinton health care plan failed so miserably?

A. There were many things the Clintons did that were tactless and tactically wrong, such as the secret task force. In this country to have a secret task force that doesn't keep any secrets is offensive. Number two, they did not invite the Republicans to the table early on. There are some wonderful Republican staffers who are knowledgeable and compassionate and they were not invited. The AMA was not well treated. But you are right: above all the plan failed because it sought to impose an egalihrian health system on a nation that is not egalitarian.

In managed care you are limiting yourself to a set of doctors, rather than having totally free choice among doctors and hospitals at the time you are sick.

Q. But since that debate has gone away, the number of uninsured Americans, particularly those who have lost their jobs, has grown. Am I missing something?

A. Not at all. We treat this problem the way we treated genital herpes. It was once a big problem, and then we got tired talking about it, and simply pretended that it went away. You have to blame the media a bit for this.

Q. How would you measure quality?

A. For one, patient satisfaction. How happy have you been with these doctors, this hospital, and these nurses? That is now beginning to be done, and the HMOs can claim cred-

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it for that.

Q. But isn't it true that some of the HMOs are denying physician-recommended care? A while back one magazine reported the case of a young woman with breast cancer who hadn't read her HMO policy, only to find that certain kinds of treatment were not covered. Is this the exception, or is this happening more and more with managed care?

A. I think this is probably the exception, but there will be such cases. The problem with our insurance system is that the coverge you buy is not standardized. So you have to read the fine print, and even lawyers don't have time to do this. For reasons like this, we actually need a little more government in health care than we have. Insurance is a product the average person cannot understand.

One reason you feel comfortable eating the food you buy is that government regulates its quality. In homeowners' insurance in this state, there is a fair amount of regulation, and I'm glad we have it. When you get a mortgage, there's government regulation involved in that, in regard to prepayment options, for example. Why can't we have a little more regulation in regard to the health insurance product we are being offered in the marketplace that would exclude the kind of fine print that the average person won't read or understand?

Why can't we have a little more regulation for the health insurance product being offered?

Q. But the Republican "revolution" was all about cutting government. They would never accept a thing like that, would they?

A. Well, they don't really mean what they say, and let me tell you why. Governor Whitman of New Jersey was the first to go on television and regulate the length of stay that HMOs must pay for after childbirth. As I tell my students, both Democrats and Republicans use the coercive power of government to tell people what to do. They just aim that power at different groups of people.

Q. The HMOs wanted a woman out of a hospital one day after childbirth. Is that nuts?

A. No, the English have done this for many years. But they follow it up with very solid home care. When some patients complained about the one-day policy here, Governor Whitman went on TV, and with big brouhaha, she and Republican legislators wound up telling private enterprise what to do. And what she said was really cute. She said, "I want to bring some common sense to this business." So you tell me that Republicans don't like regulation?

Q. Where are doctors today? Are their hands tied behind their backs more and more with managed care?

A. There is a danger of that, of course. For example, I find it objectionable when doctors have to sign agreements with HMOs that basically take away their freedom to speak. In fact, some HMOs ask doctors to sign the agreements and than make it illegal to talk about having signed these forms. That is truly Kafkaesque—like out of a horror movie. If the HMO industry knows what is good for it, it will stop this gagging of doctors or government will make the industry stop it.

Q. Specifically, what can't a doctor say?

A. In some HMOs, a doctor can't tell the patient that there is an alternative and that if you were not in this plan you might be able to get it. I think it's wrong and immoral. At some point, I think doctors have to bring that to the attention of the people and say this won't do. The other thing I think is immoral is to give the physician too much incentive to withhold care. If a doctor says, "You don't need an MRI scan," the doctor should not profit directly from that decision. ▼

As I See It...

by Paul A. Ebert, M.D., FACS
*In the Bulletin of the American College of Surgeons**

Should we have an active process through which the number of physicians and surgeons in training is regulated? As changes in our health care system progress, many individuals have stated that there soon will be an excess number of physicians and surgeons in the United States. Indeed, some people believe that such an excess already exists. The predominant theme in all of these statements is that the excess will occur in the number of specialists rather than generalists. However, even this argument is starting to weaken because some people are concerned that the number of generalists may also be excessive.

"There is essentially no stimulus within the system to reduce the number of individuals who are in residency training."

The federal government has always been reluctant to attempt to regulate the number of trainees in any field except, possibly, the armed forces, and probably rightly so. No active discussions about regulating the number of plumbers, carpenters, lawyers, paramedical personnel, and so on, are in process, so why should there be any direct effort to regulate the number of physicians in training? The only argument that could be raised is that the large number of international medical graduates who are obtaining partial training in the U.S. might be reduced, because if a large number of them remain in this country, the total number of physicians who could go into practice would far exceed the number of graduates from U.S. medical schools. However, Congress commonly responds to this argument with the fact that the immigration rights of other professions or skilled technicians are not limited, so why should American physicians have an undue protective advantage? The College has supported the concept that the total number of residency positions in this country should be defined and that distribution of specialty trainees could be determined by some commission or national body. The possibility of this proposal being adopted, however, seems to be very remote at the moment. Congress may reduce the funds that are available for the indirect support of graduate medical education, but there have not been any serious efforts to reduce the amount or number of payments for the direct support of residency salaries since 1986.

Funding for indirect graduate medical education, which usually goes to the hospital, is gradually being reduced. Would its elimination ultimately reduce the number of active residencies? It is doubtful, since there is essentially no stimulus within the system to reduce the number of individuals who are in residency training. Program directors in institutions that treat a large number of indigent patients and that provide a large volume of emergency services clearly need residents to assist in caring for these patients. Hospitals have no stimulus to reduce their number of residents, since they undoubtedly would have to find physi-

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cians, surgeons, or paramedical personnel to be replacements—undoubtedly in larger numbers—which would increase the total cost to the hospital.

Will the changes in our health system affect the number of residents in training? If so, the impact will probably be insidious, and it will occur over a long period of time. The residency review process may reduce the total number of training centers if clinical material becomes drastically reduced. However, this is a slow and difficult process, which often results in legal entanglements between the Accreditation Council for Graduate Medical Education and the training program being placed on probation or being discontinued. Even if the number of trainees today was capped at the current level of graduates from American medical schools, this reduction would make itself apparent very slowly in the active workforce. The impact would not be felt for at least a decade—and probably longer—because the number of individuals entering medical practice would probably still exceed the number of physicians discontinuing practice or retiring.

Thus, those who believe in the free marketplace system are most likely to see it in operation during the coming years, because it appears that the only way in which the number of physicians in practice will be reduced is if they are unable to maintain a livelihood in the active practice of medicine. This principle has certainly been prevalent in other countries, and there are many payors and legislators who believe that an excessive number of physicians has not, in general, reduced costs or volume of services. Rather, having a greater number of physicians has, in general, increased the volume of services provided and, thus, increased the total dollars spent for health care. A few people may argue that having additional numbers of physicians has improved the quality of health care, but this is a point that is difficult to prove.

As I see it, it is very doubtful that any active process—either through payment, congressional action, or methods available within the current system—will be activated in the foreseeable future to influence either the number of medical students or residency positions in the United States. ▼

Medicare Part B – New Correct Coding Combinations

*by Stanley Forston, Jr., M.D., M.P.H.**
Fred Robertson, M.D.†

Medicare Part B - New Correct Coding Combinations

Because of the detail and complexity of Current Procedural Terminology (CPT)* code descriptions, physicians often face the difficulty of trying to determine appropriate code combinations that best describe the services they perform. In some instances, code combinations are submitted that duplicate similar services. In other instances, code combinations may be components of a larger, more comprehensive service.

The Health Care Financing Administration (HCFA) recognized the need to develop correct coding edits for the Medicare payment system. The edit system for paying claims based on CPT codes is managed by the HCFA Central Office.

For many years, local carriers have noted serious problems with CPT code combinations that are routinely submitted for payment. As the Medicare Part B contractor for the state of Alabama, Blue Cross and Blue Shield of Alabama was obligated to pay claims based on the national edits. Local carriers did not have the authority to build edits for appropriate CPT code combinations.

A recent effort by HCFA, supported by the Part B contractors, resulted in computer claims logic that correctly identifies and processes CPT codes submitted for payment. All Part B carriers are now using the edits to pay providers for services.

CPT codes, descriptions and two-digit numeric modifiers only are copyright 1994 American Medical Association. All rights reserved.

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†Carrier Medical Director (at the time of writing).

CPT codes are analyzed and grouped according to appropriate types of services. Payment is then made based on the most accurate description of the service or services. In some instances, CPT codes that are components of a larger, more comprehensive service will be "bundled" as a single payment. In other instances, CPT codes that are mutually exclusive will not be paid individually. Mutually exclusive codes represent services that are not reasonably expected to be done at the same time for the same patient.

The impact of the correct coding policy on individual physician reimbursement will vary dependent upon the physician's billing pattern. Physicians who routinely submit codes for multiple components of services will realize an overall reduction in payments. Those physicians who routinely submit the single most descriptive code for the service provided will probably notice no change in reimbursement. As a matter of payment policy for its regular business reimbursement, Blue Cross and Blue Shield of Alabama has maintained its own correct coding edit system for several years.

The following description of Medicare's correct coding payment system was prepared by HCFA. The article also appeared in the Medicare Focus, published by Blue Cross and Blue Shield of Alabama in its November 1995 edition.

MEDICARE PART B (HCFA-1500)

New Correct Coding Combinations

Background

In August 1994, the Health Care Financing Administration (HCFA) awarded a contract to AdminaStar Federal to define correct coding

practices that would be the basis of national Medicare policy for payment of claims using the American Medical Association (AMA) Physicians' Current Procedural Terminology (CPT) system.

Policy Development Process

AdminaStar Federal developed correct coding combinations based upon review of. CPT code descriptors, CPT coding instructions, review of existing local and national coding edits, and review of Medicare billing history.

AdminaStar Federal developed a comprehensive narrative policy (the correct coding policy) which outlines general and specific guidelines for the appropriate use of CPT coding for physician claims.

AdminaStar Federal distributed the narrative policy, containing 94,000 coding combinations, in December 1994, to physician specialty societies through the American Medical Association and to other national specialty societies that represent physicians and non-physicians who may be impacted by this policy. The draft policy was also shared with the Medicare Carrier Medical Directors.

After reviewing and incorporating the comments, and receiving HCFA's approval, AdminaStar Federal developed a "code matrix" – correct coding combinations – and sent it directly to the standard system maintainers to be incorporated into the Medicare Carriers' claims processing systems. This matrix, based on the correct coding policy, will automatically identify inappropriate CPT code combinations and will properly determine payment. Existing national Medicare payment policies are not changed by the correct coding policy.

There will be two main types of code combinations implemented in January 1996:

- Comprehensive and component code combinations; and
- "Mutually exclusive" coding combinations that represent services or procedures that would not or could not be performed at the same time based on the CPT code description or standard medical practice.

Summary of Correct Coding Policy

CPT Procedure Coding Definition: The CPT procedure code definition, or descriptor, is based upon the procedure being consistent with current medical practice. In order to submit a CPT code to Medicare, the provider must have performed all of the services included in the code descriptor. Otherwise, the provider must submit a less comprehensive code. Providers must not submit codes describing components of a comprehensive code in addition to the comprehensive code. Components are services necessary to accomplish the more comprehensive procedure/service. In the rare instances where the national Medicare policy differs from instructive language in the CPT descriptor, providers should follow the national Medicare policy.

Mutually Exclusive Code Pairs: These codes represent services or procedures that, based on either the CPT definition or stand medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be submitted together.

Separate Procedures: Although certain CPT codes are identified as "separate procedures," HCFA has determined that these codes may be occasionally provided as part of a more comprehensive procedures and at those times these codes with a designation of "separate procedure" should be submitted with their related and more comprehensive codes.

Most Extensive Procedures: When CPT descriptors designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed should be submitted.

"With"/"Without" Services: Certain CPT descriptors designate procedures performed ""with" or "without" other services. Submit only the code describing the service actually performed.

Sex Designation: Certain CPT code descriptors identify procedures requiring a designation for male or female. Submit only the appropriate one of these designations for an

individual patient.

Standards of Medical Practice: Medicare considers all of the services necessary to accomplish a given procedure to be included in the description of that procedure as defined by CPT. Ancillary services necessary to accomplish the procedure are considered included, although independent CPT codes may exist for these ancillary services. Medicare considers billing for these independent CPT codes unbundling, which is prohibited.

Anesthesia Performed During Medical/Surgical Procedures: The Medicare Physician's Fee Schedule precludes payment of a separate fee for anesthesia when provided by the same physician performing the medical/surgical procedure. Therefore, do not submit CPT codes describing anesthesia services or services necessary to provide anesthesia with primary procedure/services codes.

Laboratory Panels: When CPT describes laboratory services performed as a "panel" or grouping, submit the appropriate code describing the panel or grouping. Do not submit codes for individual laboratory tests when a code for a grouping or "panel" exists for the services performed.

Sequential Procedures: There are several different instances addressed regarding sequential procedures:

- For those patient encounters where the provider finds it necessary to attempt several procedures in direct succession to accomplish the same end, submit only the procedure that is successfully accomplished. This policy generally applies to limited procedures that are unsuccessful, mandating a more comprehensive procedure.
- Procedures performed at the same session that are diagnostic in nature and establish the decision to perform the more comprehensive service may be separately submitted.

Codes added, revised, or deleted after 1994 have not been addressed in the correct coding policy. Therefore, additional instructions will be given regarding those codes at a later date.

Anyone who wants to receive information on paper and electronic options to order the correct coding should call the National Technical Information Service. To receive the information by Fax, please call 703 487-4140 and enter code 8657. To receive the information by mail, please call 703 487-4650 and ask for PR-1030.

Please submit concerns about correct coding edits in writing to:

The Correct Coding Initiative
AdminaStar Federal
Post Office Box 50469
Indianapolis, Indiana 46250-0469

The correct coding edits will be revised quarterly as part of the refinement process.

Use of the Temporary National Level II HCPCS Modifier "GB"

"Distinct procedural service: the physician may need to indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury in extensive injuries)."

In those instances where it is necessary to indicate that a procedure or service was distinct or separate from other services performed on the same day, such as:

- a different session or patient encounter
- a different procedure or surgery
- a different site, separate lesion, or separate injury (or area of injury)

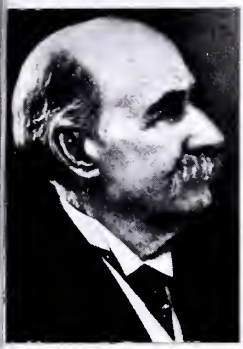
Application of the "GB" modifier will prevent erroneous denials of claims for several procedures performed on different anatomical sites, on different sides of the body or at different sessions on the same date of service. The medical record must reflect that the modifier is being used appropriately to describe separate services.[1] ▼

BIBLIOGRAPHY

Medicare Part B (HCFA-1500), New Correct Coding Combinations,"Medicare Focus," November 1995, pp. 17-20.

John Allan Wyeth, MD, L.L.D. Confederate Soldier, Surgeon And Author

*by Paul S. Howard, MD**



John Allan Wyeth

At the turn of the century New York City had eclipsed Philadelphia as the center of medical knowledge and education in America. Earlier in the eighteenth and nineteenth centuries Europe was the mecca of medical care. John and William Hunter had begun teaching students the intricacies of the human body with cadaveric dissections in the 1700s making England the most important source of medical and surgical knowledge at that time. By the 1840s Paris had become the center of medical education in the world. Rene Theophile – Hyacinthe Laennec, Dominique Larrey, Francois Broussais and many other practitioners roamed the halls of Parisian hospitals attended by dozens of young doctors seeking clinical knowledge on the practice of medicine. In fact, during the 1800s Paris had become the most common overseas destination of young American doctors-in-training as America did not have the population density to support large teaching hospitals with the patients necessary to provide bedside clinical training. There were fifteen medical schools in America during the 1840s, none of which provided adequate bedside training for young doctors. Later in the nineteenth century surgery emerged as a separate specialty distinct from medicine. Surgical training was then formalized in Germany by the famous surgeon Theodore Billroth. The center of the medical world had shifted to the German speaking countries by 1880, where it was to remain until the first World War.

John Allan Wyeth in the summer of 1901 was the Surgeon-in-Chief at the hospital he had founded – The Polyclinic Medical School and Hospital in New York City. John Allan, as his southern friends called him, had founded the Polyclinic in 1881 and was appointed Surgeon-in Chief at 36 years of age. Wyeth, now 52 years old, was operating at the Polyclinic as he usually did on Mondays but on this particular hot and humid day he was not himself. One can only surmise the thoughts of the great surgeon as he addressed his students and visitors as depicted in the only remaining photograph of Wyeth at work. There are at least ten doctors with Wyeth on the day in question in 1901 and this is what they saw.

Professor Wyeth had just entered the operating theater when the photograph was taken from a balcony seat. Wyeth was preparing to operate on a young patient of 16 years who had been diagnosed with a neck mass. As Wyeth looked up, gently keeping his hand in contact with the young man's forearm, he spoke with a tired and weak voice. This was not in keeping with his reputation as a strong willful man, politically savvy but at times too intense and even obstinate. Because his voice was weak many of his visitors were forced to lean forward to catch every word. Today's case was particularly interesting as Wyeth had published extensively on the anatomy of the lower neck region and had been dutifully rewarded by the American Medical Association in 1876 for his studies. Perhaps Wyeth was showing his age as

*Dr. Howard is a Birmingham plastic surgeon.

a manifestation of years of leaning over the operating table. He is slightly bent at the upper back and has constant neck pain from leaning over a table whose height cannot be altered. His blue eyes are deep set and today are bracketed with dark circles. His balding pate glistening with perspiration accentuating his large forehead and aquiline nose. As a clinician he carried the reputation of being kind and considerate to his patients. In the operating room he was meticulous and intense and had the attributes thought necessary for a surgeon: the eye of an eagle, the heart of a lion and the hand of a woman.

Though suffering from fatigue Wyeth was always considered in his speech and always a gentleman. The tiredness in his voice tended to make his southern accent more pronounced and distinctly different from his New York City colleagues. John Allan was born and raised in Madison County, Alabama, and was forever proud of his southern heritage but had found his livelihood in New York. Wyeth had struggled (since the Civil War) to reunite doctors from Northern and Southern heritages and was recently elected President-elect of the prestigious American Medical Association. He was only the third Alabamian to be elected to that esteemed office in the post-Civil War era. Perhaps the heavy weight of medical reunification increased the burden carried on Wyeths' shoulders.

After presenting the young boys case to the visiting doctors, Professor Wyeth turned his attention to the surgery at hand. The anesthesia was to be administered by his assistant, the young Dr. Davenport. The fumes of the sulfuric ether mask permeated the room. Dr. Wyeth and his colleagues were always very concerned at this moment during the operation as anesthesia was still in its infancy with many complications possible. The first documented surgical procedure under anesthesia had been performed in Boston in 1846, also on a neck mass in a young patient. The techniques had not progressed very much since that time. Luckily the boy responded well to the ether and was breathing easily. In addition to the invention of ether and chloroform anesthesia was the work of Joseph Lister in Great Britain and Oliver Wendel Holmes in Boston regarding the germ theory of infection. Lister had been a proponent of carbolic acid as a disinfectant for the patient's skin, the surgeon's skin and the surgical instruments. Not all American surgeons were convinced of the efficacy of "Listerism" but Wyeth was convinced that hospital infections would be reduced by meticulous technique and cleanliness. More recently William Halsted in Baltimore and others were touting the use of surgical masks and Latex surgical gloves. Wyeth often spoke of Halsted but had not been convinced of his newer and more radical thoughts on the spread of infection. At midsummer in the year 1901 all of the visitors at the Polyclinic were happy to not have hats and masks adding to the already stifling heat.

As Professor Wyeth began the operation it became clear why he carried such a good reputation as a surgeon. He was bent at the neck and upper back, his vision, unaided by eyeglasses was clear but his best attribute was his hands. They were large and nicely manicured in a masculine way; they moved fluidly without hesitation which gave one the impression of speed but without fast movement. No movement was wasted and no step repeated. All of these deft maneuvers were made even more evident by the size of his hands and fingers. His fingers were long yet supple with their size exaggerating every movement. He worked in a

rather deep incision but was not at all encumbered by the size of his fingers working in the depth of the wound. The performance of the operation seemed to heighten his intensity and alertness. At one point he even became animated while describing a particular point of anatomy in the neck. His visitors often wondered why a man so intellectually vigorous was so physically frail. He occasionally would stop an operation to cough and breathe deeply. It was years later that Wyeth would write his autobiography With Saber and Scalpel (1914) and it would become clear that much of his frailty stemmed from the illnesses he suffered during an 18 month period as a Prisoner-of-War in a Union prison. In fact, he was the age of the patient when he was captured in Tennessee.

With the neck mass out we all understood clearly the basis of Wyeth's reputation as a clinician and teacher. The Polyclinic and John Allan Wyeth had revolutionized medical education in America, bringing it up to the lofty standards that had been formerly available only in the largest European medical centers. How this highly skilled surgeon from Alabama had come to be the preeminent surgeon in New York City is an interesting tale of sacrifice and dedication.

John Allan Wyeth (1845–1922) was descended from English, German, Scots and Welsh ancestors who settled in Massachusetts in 1630. Each of his grandfathers served bravely in the Revolutionary War in the fight for independence. Louis Weiss Wyeth (John Allan's father) received a classical education, studied law and eventually settled in Marshall County, Alabama in the year 1836. Appointed judge, Wyeth was to later win election to the, Alabama State Legislature where he came to know the famous gynecologic surgeon, J. Marion Sims from Mt. Meigs and Montgomery. Judge Wyeth married Euphenia Allan, the daughter of a Presbyterian Minister, John Allan on April 8, 1839 in Huntsville, Alabama. John Allan Wyeth was the fourth and youngest sibling from the marriage. Judge Wyeth was later to found the City of Guntersville, Alabama, where John Allan was raised.

John Allan Wyeth, a first generation Southerner, experienced and later wrote eloquently of his childhood experiences in Guntersville. He was especially articulate about his experiences with Negroes and "chattel slavery." He wrote of the "chagrin of manner, the pride of family – the 'quality' as they so aptly termed it – the sentiment of loyalty, affection, and trust which characterized the relation between these faithful, patient, submissive and happy creatures...." This opinion of the pre-Civil War Negro was commonplace among the slave owners of the day. Of course, this was in distinction to the true mood of the 1830s and 1840s when free Negroes, mainly in the North, were organizing and inciting the slaves to riot for their freedom in the South. Many of these uprisings, especially the one incited by the infamous Nat Turner, had become violent and led to many deaths, arrests and imprisonments. Many young boys had so exaggerated and fantasized about the Negro uprisings that the fear of "mad dogs and runaway niggers" sent a chill up the spine during their solo excursions through the woods.

John Allan, in 1860, passed the college entrance exam and matriculated February 1, 1861 at Lagrange Military Academy. After only one year in college, Alabama seceded from the Union so young Wyeth quit college to follow his friends into military service for the Confederacy. His parents persuaded him to stay home because of his small stature (he was 15 years old), and because they wished him to work the farm in his fathers absence. Judge Wyeth had enlisted and went to the front that year. John Allan dutifully stayed home and worked the family's 10 acres of corn until December 1862. Quite unexpectedly the Wyeth's were asked to care for Lt. Frank Brady, who sustained a shoulder wound in a skirmish near Huntsville. Although this episode with the care of Lt. Brady is not mentioned by Wyeth as one of the motivating factors for a medical career, it surely must have served as an early introduction to his future career. Lt. Brady recovered and was ordered to make the forced march to Kentucky. He allowed John Allan, who was still too young to

enlist, to join Quirk's Scouts as an independent. The Kentucky expedition lasted until February 1863 and the young Wyeth returned a seasoned scout and a much wiser young man.

With the approval of his parents John Allan enlisted with Company I of the Forth Alabama Cavalry in April 1863. The fourth Alabama was an active unit undertaking numerous engagements in Tennessee and Alabama. John Allan was a capable soldier utilizing his riding, shooting and general abilities as a Southern outdoorsman. On October 4th, 1863, John Allan was taken prisoner by the Union forces and sent to Camp Morton, Indiana. The journey to prison was almost too much for John Allan. The first stop on the trip was a two day stay at the Tennessee State penitentiary where he contracted a cold which became pneumonia. He had hardly recovered from pneumonia when he contracted the measles. Wyeth spent his first three months in captivity in the prison hospital recovering from the measles and pneumonia. In February 1865, Wyeth was included in a group of approximately 500 prisoners of war who were "hopeless invalids." and were given an early parole home. John Allan survived the war but returned a much different man from the adolescent who went to war.

Wyeth decided on a medical career and luckily found the entrance requirements for medical school at the University of Louisville were not strict (he had not graduated from college). He matriculated in the fall of 1867 at 21 years of age and graduated on March 2, 1969. Dr. Wyeth, with virtually no clinical experience in medicine, returned to Guntersville, Alabama and hung his shingle. Quickly Wyeth found that the practice of medicine was an awesome responsibility, not to be taken lightly, and found his preparation for the practice of clinical medicine lacking.

As many other Southerners had done, Wyeth sought further medical training in the North and moved to New York City where he matriculated at Bellevue Hospital Medical School in 1872. Much of this time was spent in the dissecting room and surgery clinics where he became, for the first time, interested in surgery and pathology. He graduated with the *ad eundem* degree March 1, 1873. Having found his metier, Wyeth became assistant demonstrator of anatomy for one year, then became prosecutor to the Chair of Surgical Anatomy, a post he held from 1874 until 1878.

Practicing in New York City, Wyeth developed into a first class academic surgeon and soon began to contribute to the surgical literature. His first major publication was an anatomic study of the foot with special regard to the Syme amputation (James Syme, 1799-1870, father-in-law to Joseph Lister). The study won an award from his new alma mater in 1876 and was followed by two exceptional anatomic studies of the carotid and subclavian arteries. Both were to win American Medical Association awards in 1878. Dr. Wyeth had now proved himself as one of the leading surgeons in New York at the tender age of 33. Despite his chronic health problems, Wyeth proved himself an indefatigable researcher who was considered to have unreproachable integrity.

In 1878, with his energies now directed toward a new system of medical education in America, Wyeth traveled to Europe and visited the great medical centers in London, Paris and Berlin. Wyeth had made the acquaintance of J. Marion Sims in 1877 and was to visit the Sims home in Paris on his European tour. Sims had known the elder Judge Wyeth as an Alabama legislator while in Montgomery and was gracious to his now renowned son John Allan Wyeth. The friendship that developed was to last until Sims' death in 1883.

Wyeth returned to New York to complete the work on his dream for the first post-graduate medical school in America, The New York Polyclinic Medical School and Hospital which was to open in 1881. Wyeth consulted with Sims whenever possible and it is highly likely that Wyeth would have convinced Sims to join him in this effort if Sims had been a few years younger and in better health. Wyeth became Surgeon-in-Chief and Professor of Surgery to the Polyclinic at the age of 36. He was later to become president of the institution.

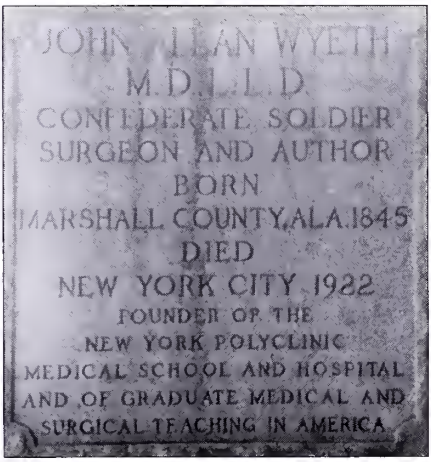
The development of the Polyclinic should

not be underestimated as it was to change the face of medical education in America. Recently graduated medical students did not need to seek other medical opportunities to supplement their inadequate medical school clinical training overseas any longer. Wyeth provided the American equivalent to the post graduate experience offered in Paris, London, Dublin and Edinburgh. The personal attributes that allowed Wyeth to succeed in the Polyclinic endeavor are the same attributes that placed him in the forefront of the reunification of the Northern and Southern physicians after the Civil War. He was an intelligent, compassionate, ambitious, independent and courageous man, who as President of the American Medical Association in 1902, helped to soothe and overcome the longstanding differences in the medical community between the North and the South.

John Allan was also to show his common sense and good taste in his choice of a wife. He married one of the "beautiful Sims girls" he met in Paris, the youngest daughter of J. Marion Sims – Florence Nightingale Sims. The marriage in 1886, three years after the death of J. Marion Sims, was to produce one daughter and two sons.

Wyeth was a prolific writer and contributed both to the medical literature and the lay literature of the time. He wrote two novels, one his autobiography With Sabre and Scalpel and the second, a biography of Lt. General Nathan Bedford Forrest, founder of the Klu Klux Klan. He wrote eloquently of his southern experiences in the Civil War but lived a long and fruitful life outside the South in New York.

John Allan Wyeth was a complex man with his roots in the South but an intellect and ambitions that led him to make a lasting and important contribution to medicine, surgery and medical education in his second home, New York City. He was probably one of the greatest medical politicians of all time and was elected President of the prestigious New York Academy of Medicine (1901) as well as the American Medical Association (1902). Nineteenth Century Alabama produced three men in the post-Civil War era to be elected to the Presidency of the American Medical Association – J. Marion Sims, W. O. Baldwin and most unlikely, John Allan Wyeth, who spent 18 months as a P.O.W. in a Union Prison.



The photograph that stimulated this story about John Allan Wyeth was not dated but was believed to have been taken in the year 1901 at the Polyclinic in New York City. There remains today a statue on the capital grounds in Montgomery, Alabama dedicated to John Allan Wyeth, M. D., L.L.D., Confederate Soldier, Surgeon and Author. ▼

BIBLIOGRAPHY

Carmichael, Emmett B. John Allan Wyeth. Bulletin of the History of Medicine, Vol XVIII, No 3, Oct, 1945.
Wyeth, John Allan, With Sabre and Scalpel. Harper Bros, New York,

*Ernest S. Campbell, M.D., FACS

Dr. Campbell is a retired general surgeon living on Ono Island, Alabama Gulf Coast. His family consists of Ann, his wife of 47 years, three married children, and eight grandchildren.

This is the first in a series of columns he agreed to write to introduce physicians to the arcane world of computers and the Internet, at which he is expert, despite his denials.

After graduating from high school in the city of his birth, Selma, he attended Auburn University for two years before receiving his B.S. from the University of Alabama in 1951. Following his M.D. degree from Medical College of Alabama in 1955, Dr. Campbell interned at Philadelphia General Hospital and then served in the U.S. Public Health Service (1956 58).

After two years of general practice in Birmingham, he accepted a residency (1960-65) in general surgery at Carraway Methodist Hospital, Birmingham. Inducted as a Fellow in the American College of Surgeons in 1967, Dr. Campbell practiced surgery at Brookwood Medical Center in Birmingham until his retirement in 1992.

He and Mrs. Campbell searched widely before finding their special island, Ono. His life now is devoted to writing, fishing, sailing and scuba diving. He has written on a variety of subjects for Alabama Medicine and the Alabama M.D. A medical column, "The Doctor is In," is a popular feature of The Perdido Pelican, a local newspaper in the Orange Beach area.

Having achieved the level of Advanced Rescue Diver with PADL, he helped inaugurate "Scubatimes Online Medical Center," on the World Wide Web, a site dedicated to diving medicine. He has his own personal Web page, where you will find links to all his Perdidio Pelican columns and other information, including, proudly, the names of all his grandchildren.

When he is not writing, fishing or scuba diving (he has made more than 1,300 dives), Dr. Campbell may be found aboard his 30 foot catamaran cruiser. He holds a US Coast Guard 50-ton Master's license, with sailing endorsement. The bay waters of Mobile, Perdido and Pensacola are ideal for sailing, he says, but he has also navigated the Intracoastal Waterway, the Atlantic off the East Coast of Florida, Lake Okechobee, the Gulf along the West Coast of Florida, the Sir Francis Drake Channel in the British Virgin Islands, and wherever else his wanderlust has taken him.

As a consultant to Scuba Times Magazine and Scuba Times Online, he has written extensively on diving medicine and maintains a continuing interest in hyperbaric medicine. For additional information on Dr. Campbell's life and work, see his Website (http://www.gulftel.com/~scubadoc/) or point your browser to Digital's "Alta Vista" search engine (http://www.altavista.digital.com/) and simply type in "divedoctor" in the query panel.

If you can catch him between dives, cruises or fishing expeditions, he will respond to physicians' email questions: divedoctor@earthlink.net.

Alternatively, pose your questions to Bill McDonald at MASA (voice, 334 263 6441 or 1 800 239 6272; fax, 334 269 5200; email, macmasa@aol.com.; snail mail, PO Box 1900, Montgomery, AL 36102) for relay to Dr. Campbell by whatever mode of communications offers the highest probability of catching him at a given time.

- W.H.McD.

PART I
Computing

*by Ernest S. Campbell, M.D.**

Dr. Campbell's very popular five-part series on the computer and the Internet, published during the summer in The Alabama M.D., is reprinted on the following pages in response to many requests.

"Computing" as a hobby has pretty much saved my retirement from a purgatory of boredom. One can only sail, fish and play just so much and all days are not suitable because of the weather. I'm not the inveterate fisherman that some of my friends claim to be, golf is just not my cup of tea and my other love, scuba diving, continues to be enjoyable, but these trips come only in widely spaced interludes of 1-2 weeks, months apart.

The computer, on the other hand, is always available, ready to go, and, if treated right-is willing to do just about anything you ask of it -at any time, regardless of the weather. It's relatively inexpensive, takes up very little space and can perform hundreds of chores, most of which are done better and much more rapidly than any other way. One of humankind's greatest accomplishments, the computer has not even touched its potential.

Most doctors don't relate well to computers even though they might have one in their office. This is mainly because of unfamiliarity with the terminology and the lack of time to gain the experience needed to become at ease with the simplest of computer exercises. Most doctors, however, already have the built-in skills that work hand-in-hand with computing-hand-eye coordination, analytical abilities, gathering and compartmentalizing of facts and deductive reasoning. Applying these skills to computing really simplifies the transition to the utilization of a fantastic source of information and a well-spring of enjoyment that's unsurpassed.

Simply stated -all the computer does is act as a filing and storage system for millions of bits (bytes) of information. Utilizing only two answers, yes and no, or 1 and 0, this information is stored as data, photos, charts or whatever type of information you give it and then spews it back out to you at the punch of a keystroke or the click of a mouse. A mouse is a rolling ball in a case that delivers a moving arrow (cursor) on the monitor (TV) screen. The way it does this is through hardware (built in wires, chips, printed boards, modems, printers, keyboards, speakers and monitors) in the CPU (central processing unit and software (systems developed to direct the traffic of the bits of information in and out). Some software comes installed in the computer; some you buy and install yourself; and some you download from networks, usually for free but sometimes for a small fee.

Information is stored in the hard drive of the computer, on "floppy" discs and on CDs. Information can also be accessed over telephone lines via a modem (connector) similar to the one used in your fax or to transmit your credit card information. This modem sends data at varying speeds described in bps (bytes per second), the faster, the quicker your trans-

missions and ultimately the less the cost. A 28.8 modem is a must if you are going to do much work on the Internet, this is at the rate of 28,800 bps. Online services such as AOL, Compuserve and Prodigy have their own cadre of telephone lines and modem capabilities in local areas and sometimes are pretty well tied up by the volume of usage. I've found that the best thing for me to do personally is to have an account with a local TCP-IP server, usually a local company, that's somewhat more expensive, but much more reliable.

I suggest buying the best equipment possible right from the start-because as you progress in your personal knowledge and experience with the computer your needs will also grow. As time passes, upgrades of software (as with the advent of Windows 95 and the development of the Internet has shown) require corresponding upgrades of storage capabilities (RAM) and speed (semiconductors or chips). My original computer, a relatively inexpensive Radio Shack Tandy 286 that was the latest thing five years ago, would now be like a Model T Ford flivver compared to the Pentium 120 that's now required to run the present-day software needed.

In addition, get good peripherals-color printers, monitors, scanners, speakers and faxes so that you can make optimum use of the information available to you through the Internet, online services, CDs and software. You'll be pleasantly surprised at the jobs that you can do that will actually make your life easier; e.g., research Medline for the answers to sticky diagnostic /treatment problems, keep up with the latest changes in criteria for disease management, use drug interaction profiles and get a complete printout of a medication for a patient handout. You can write papers, make presentation slides, use desktop publishing, buy airline tickets, get hotel reservations, buy and sell stock, and participate in lively one on one conversations with your peers (or less!) in discussion groups. Communication is possibly the most valuable use of the computer. It can be accessed for sending faxes or E-mail, used as a word processor for typing and formulating letterheads and letter mail (snail mail).

I plan to delve more deeply into the computer and its uses in upcoming articles, but first the thing to do is "just do it!" – get started. Go to a computer store in your neighborhood that sells and repairs components and find out if they will put you a computer together and what is their service policy. Talk to the owner— who will be interested in your return business and not just interested in selling you a computer and ask for a computer that has Pentium 120 or above, 8 megabytes of RAM (random access memory) or better, a modem with a speed of 28.8bps or better and an SVGA monitor 17" in size, a CD ROM, a speaker system and a color printer. Read all the material that comes with the computer and get a good instructional manual from the same place. Be sure that the computer is loaded with Windows 95 and has online access software. Talk to the computer store owner about "TCP/IP" access and where it can be obtained in your area.

Once you're up-and-running and online, the rest is easy – just follow your inclinations as to "Net surfing and exploring. As you gain proficiency you'll develop your own likes and dislikes for hardware and software. Later on we'll discuss online services, word processing, Internet usage, and eventually in building your own Website or homepage.

PART II
Surfin' The Internet

The Internet computer network, a worldwide connection of seemingly endless sources of information is taking millions of users to places on the globe that could only be dreamed about a few years ago. Commercial and private use of the Internet has grown exponentially over the last few years. Its estimated size increases by more than 10% per month. The Internet just keeps on growing.

The handful of computers linked in 1969 has grown to nearly 5 million today. Today's reported 30 million Internet users worldwide is projected to grow to 100 million within five years. Although the predecessor of the Internet as we know it has existed since 1969, few physicians have taken full advantage of its extensive and continuously expanding resources. This may be due in part to the perceived difficulty of navigating the sometimes circuitous routes to the data sources of interest.

Advances in telecommunications technology in the last decade have fostered the development of computer networks that allow access to vast amounts of information and services. Of the many computer networks that have been developed, the most prominent is the Internet. Originally intended to be a way to share computing resources among academic and research institutions in the United States, the Internet has gradually evolved into a worldwide network of computers that provides various services reflecting the eclectic nature of its component networks. The recent upsurge in interest in the Internet is due to several mutually reinforcing factors: increased ease and availability of access to the Internet, lower access charges, faster communications, and more organizations offering commercial and noncommercial services over the Internet.

Of particular interest to the medical community is the large and increasing number of technical, scientific, and biomedical resources that can be accessed through the Internet. Most large medical centers have publicly accessible information, and some large organizations, such as the National Institutes of Health, have extensive databases and services that can be used by medical researchers, clinicians, and educators. In addition, many medical organizations and some medical journals are advertising their services over the Internet and can be contacted through electronic mail.

As the cost of telecommunications decreases and the speed of telecommunications increases, new forms of computer communication, such as long-distance, real-time audio, and video services will become available. Computer networks in general and the Internet in particular are likely to play more important roles in many aspects of medicine in the future.

Newer and substantially more user-friendly interfaces have been developed recently, allowing simpler and more direct access to the full range of Internet resources. Arguably the most important of these is the National Center for Supercomputing Application's Mosaic, the link to an information domain known as the World Wide Web.

In Part I we discussed generally the use of personal computers by physicians and the basic needs for an efficient home or office

computer that could access the many services of the Internet.

Only recently could you even imagine chatting online (E-mail) with a friend over the Internet "phone" link (as I do daily with friends in St. Thomas, Oregon, California, Norway, Germany, Singapore, Hong Kong, etc.) for only the cost of a telephone connection. Could you possibly have predicted that you could access the National Library of Medicine from your desktop computer, look into the archives of the Vatican or CIA, pull up the most recent issues of such magazines as *The Smithsonian, Atlantic Monthly, National Review* or browse a book store, automobile showroom or purchase your airline and hotel tickets directly from your desk? These and many more exciting possibilities are available through an online connection between your computer and the Internet and the worldwide web (WWW).

Mice and "Browsers"

All of these things can be yours at the touch of your fingertips on a "mouse" and with a few clicks of the mouse (movable guide on the desk with a cursor on the screen). All that's needed is an online telephone connection to a dedicated server computer that is able to hook you up with the Web and the appropriate software installed on your computer to act as a "browser" to utilize the line. Two of the better browsers are Netscape "Navigator" and Internet Explorer, both of which can be downloaded free on the Internet. Along with software that sets up your E-mail, such as Eudora Lite (also free) you can easily "Surf the Net!"

Modem

The one other important thing to have is a "modem," hardware that allows your computer to talk to the other server computer, sometimes at great speeds. All of us are familiar with the fax modem and its noises. A modem is used by all fax machines and is usually capable of sending messages at the rate of 14,400 bps (bits per second). The best thing to do is to get a computer that already has a built in modem of 14,400 or 28,800 bps (the faster the better). If you don't already have a modem of this speed, one can be bought and either attached externally or inserted in the computer as a card.

Modem is short for MOdulate and DEModulate which is what it does to computer information for transmission. This turns digital information into sounds (analog) so it can travel over a telephone line, and then be returned to a digital form in the other computer. External modems are much easier to install, more portable but are more expensive because of the extra wiring required for plug-in to extra power supply, and the case required. Internal modems require opening up the insides of the computer and reconfiguring the software drivers, which can be a royal pain in the butt! Portable computers can use a credit card-sized PCMCIA or PC Card modem. These are expensive but easy to install and have options such as compatibility with cellular phones.

No matter what kind you get there are some things you should look for. Be sure that your modem is Hayes-compatible. Hayes was the first company to be widely successful and its AT command system is the most used and supported. As I noted before, get the fastest speed you can get, preferably 28,800bps. The higher speed modem you use, the less time you will spend waiting on graphics and large text files to be downloaded to your computer. My first computer had a 2400 bps built-in modem that was slower than growing grass and seemed to take hours to download a simple page of the Internet.

Modems in computers with fax capabilities merge the capabilities of the computer and the fax machine. This allows you to take information on your word processor in your computer, send it as a fax and receive information on your computer and print it out.

Online Services

Online services such as Compuserve, Prodigy, Genie, MSN and America Online have their own "browsers" (software that allows you to interact with the Internet) and they are probably the easiest way to get online and explore the worldwide web (WWW). Once you get online you can start using E-mail, Gopher, WAIS and the World Wide Web. As you get comfortable with your computer you can change to a local server that will provide you with more online time and eventually build your own website (Homepage). The expense varies directly with the amount of time you want to use the service and most of the local services provide very good technical support and backup.

Continuing Education

As a tool for continuing education the Internet is unsurpassed. The technology is revolutionizing education and is beginning to be utilized by medical schools. Global networks, powerful personal computers, and user friendly, graphically oriented software are creating a new infrastructure that promotes rapid, efficient access to information. Images, text, audio, and video can be integrated into interactive multimedia presentations, providing a hierarchy of knowledge that can be traversed by the click of a mouse. Because the components (text, images) of educational presentations are stored electronically on a network rather than on the printed page, an individual component can be linked and bundled into as many different presentations as desired. Furthermore, components of information can exist on different computers throughout the world and yet be linked by software into a single presentation.

Electronic mail probably provides the most utilitarian aspect of the Internet spectrum and will possibly be the area most used by the physician. In Part III I'll go into greater detail in the advantages of its use.

PART III
E-mail and How it's Used

Physicians traditionally have relied on two things to communicate: the telephone and their office staff to type letters that they have dictated. The art of personal letter writing has been all but forgotten in their search for time-saving contacts with their fellow physicians.

Now, physicians have a fast, cheap, global and unique communication method that in most respects is better than the telephone, faxes, courier shipments or conventional letter mail. Electronic mail (e-mail), no longer the tool of scientists and corporations, is now enabling physicians to communicate both efficiently and inexpensively around the world.

Reviving writing skills that generally have lain dormant for years, doctors can now sit down and "hunt and peck" to their hearts content and instantly get in touch with a friend, write a letter to the editor, chew out a senator or representative or chat with children off at school.

Messages arrive at the addresses of specific people seconds after they are sent and cost only the dial-up time on your server. Each person has his unique address on the Internet and all of this is available all over the world.

Most businesses have specific addresses for e-mail and you probably have noted that some cards, ads, and letterheads have e-mail addresses in addition to the usual telephone and fax numbers. Using e-mail is a great way to get rid of "telephone tag" and avoids the fax machine that's often busy. E-mail appears directly on your computer screen, ready to read at your leisure and capable of being printed and stored. The rich content of your message is much more personal and your message is conveyed in a less sterile fashion.

With the proper software, you can attach computer documents that you have created, copy important quotes from other areas of the Internet and paste them into your letter, copy and paste references to your work and send carbon copies to other interested people. You can also send "blind" copies to people without the knowledge of the original recipient.

The user at home now has an entirely new way to stay in touch with friends and family–without getting the infuriatingly inevitable and ubiquitous voice recording. Instead of the back and forth of one recording talking to another-you can send your messages and have them read by the other person at their convenience—-and they can reply at their leisure.

The Internet has allowed all this to happen, uniting a large number of smaller e-mail services into one large worldwide system that can transport messages virtually anywhere in the world. An example of this system is the question and answer website that I'm on regarding diving medicine, Scubatimes Online. This website, which is located in Los Angeles, receives questions from people from all over the world about diving medicine. These questions are then copied to me, I answer them directly back to the questioner via the Internet with a blind copy to the webmaster who then can insert them into the web page for publication.

Every day I'm in contact with someone

from faraway places such as Europe, Australia, Hong Kong, Singapore, the Middle East, South Africa or from someone close-by, all with interesting diving medical problems. Several of these have turned out to be semi-emergencies and hopefully we've been able to avert some major diving problems, as in the lady who wanted to dive 6 months pregnant, or, the Swedish lady with an ear perforation who couldn't understand why her ear hurt and she got very dizzy when she dived.

Most people will find that they will spend 5 or 6 times as much time using e-mail than with any other aspect of the computer, and becoming comfortable requires a little knowledge in a few nuances of e-mail etiquette.

Sending e-mail requires having an e-mail address yourself and knowing the address of the person to whom you are writing. When you sign up with a provider, you will be given an e-mail address, the first part is usually your log-on identity, e.g. "scubadoc" or your name or a set of letters or numbers and dots, followed by the sign @ and then the identity of your service provider. My service provider is Earthlink Network, a company in California; my sign-on identity is "divedoctor," so my e-mail address is "divedoctor@earthlink.net." When I was on America Online, my address was ESCdive@aol.com; the .com indicating that the server is a commercial entity. Similarly, government entities use .gov and educational Internet users .edu with users outside the United States often having a designation indicating the country of the users service. All you need to know is that the addresses have to be exactly as written, with all the dots and tildes in the proper position.

It's important to remember that e-mail is subject to the Federal Rules of Civil Procedure and you need to be careful what you say in your e-mail letters, since they can be subpoenaed and copies used in litigation of court cases, business disputes and political campaigns. because of this, you need to mind your "netiquette" or e-mail etiquette. Here are some simple rules to keep you out of trouble:

1. Never put anything in an e-mail that you wouldn't be proud to say directly to the person or to testify to under oath.
2. Never send a letter when you are emotional; similar to "never going to bed angry with your spouse." Typed messages lack the tone of voice that telephone conversations have and the recipient may misinterpret your meanings.
3. Make sure that your addresses are correct and that you are sending mail to the right person. Keep your messages short and break up your paragraphs for easier reading.
4. Limit your replies to the part of a received message that matters: don't quote the entire message.
5. Before attaching a file, find out whether or not a recipient can read an attached file in its native format; such as "MIME, BinHex," etc. Most use MIME and can receive exactly the document that you have sent. If not, they can download the appropriate Viewer from the Microsoft WWW site on the Internet (free).
6. Don't send messages in CAPS. It gives the impression that you are shouting.
7. Try to have a sense of humor with your writing and not be so stiff.

Some symbols that you might see in your e-mail include smiley-faces :-), sad smileys:-(, sarcastic smileys :_), double-chinned smileys:-)) and the list can go on and on. There are also abbreviations that you will run into that may not be so easy to decipher: BTW-by the way; EOD-end of day; FYI-for your information; FAQ-frequently asked questions. You can find a lot more of these by using one of the search engines (Yahoo!)and use the keywords "smiley" or "netiquette."

You can transmit zipped files, videos, or

just about anything in your computer, including pictures, audio files and applications. If you have Internet Assistant for Word (free), you can convert your Word file into HTML (Hypertext Markup Language) and the resulting file will arrive at your recipients mailbox as a World Wide Web page, with all the bells and whistles!

The next time you're considering a letter or a fax, find out if the person has an e-mail address. E-mail is really simple and less expensive than a fax and the person will thank you for getting the information there quicker and making their work easier. It also provides a complete electronic file of your correspondence making it easier to reach when you need it. I believe that next to actually talking face to face it's the best way to communicate in these times of having to leave a "paper trail."

"Every man is rich or poor according to the degree in which he can afford to enjoy the necessities, conveniences, and amusements of life."

Adam Smith (1776)

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PART IV
Entering the "Land of the 'puter braindead"!

We talked about "Surfin' the Internet" previously and I have had several requests to be somewhat more specific and try to reach the "Land of the 'puter braindead"! Well, having been dead and brought slowly back to life myself, here goes another try at transmogrification.

The Internet is a global network of computers that communicate using a common language. When you connect to a "browser" such as Netscape, Internet Explorer, Mosaic or any of the browsers used by online services (America Online, Prodigy, Compuserve or the MSN web sites), you are connected to the Internet. A "browser" is a software tool that you use to look at web pages. This software can usually be found on the Internet free for the downloading. ("Downloading" means transferring from one computer to another.) The Internet is similar to the international telephone system — no one owns or controls the whole thing, but it is connected in a way that makes it work like one big network.

About forty million people have Internet access today. The World Wide Web (the web or WWW) gives you a graphical, easy-to-navigate connection for looking at documents on the Internet. These documents, as well as the links between them, comprise a "spider web" of information.

The web lets you jump or "hyperlink" from one web page to other pages on the web. You can think of the web as a big library. Web sites are like the books, and web "pages" are like specific pages in the books. Pages can contain news, images, movies, sounds, radio, telephone, 3D worlds — just about anything. These pages can be located on computers anywhere in the world. When you are connected to the web, you have equal access to information worldwide; there are no additional long-distance charges or restrictions.

The World Wide Web is changing the way people communicate all over the globe. This new global medium is gaining popular acceptance faster than any other communications medium in history. Over the last two years, the web has grown to include a vast array of information — everything from stock quotes to job opportunities, bulletin boards to news, previews of movies, literary reviews, and games. The type of information ranges from the most obscure to the most globally important. People often talk about "surfing" the web and visiting new sites. "Surfing" means following hyperlinks to pages with subjects you may never have heard about, meeting new people, visiting new places, and learning about things from all over the world.

Remember, the Internet is not just about corporate or scientific information. Because it is very easy to publish on the web, many individuals have set up personal "home pages," pages about themselves and their interests, pictures of themselves, and more. My own "home page" is served by Gulf Telephone out of Foley, Alabama, but I'm able to add and delete items from my personal computer, updating it on a regular basis. This information is available to anybody in the world who has web aecess.

A "home page" is the starting point for a web site. It is something like the cover page or

the Table of Contents of a book. Each web page, including a web site's home page, has a unique address called a Universal Resource Locator (URL). My page's address is "http://www.gulftel.com/~scubadoc/". Pages on the web are interconnected. You connect to other pages by clicking text or graphics that are called hyperlinks. Hyperlinks are underlined or bordered words and graphics that have web addresses (also know as a URL — Universal Resource Locator) embedded in them. By clicking a hyperlink, you jump to a particular page in a particular web site. You can easily identify a hyperlink. Hyperlink text is a different color from the rest of the text in a web site. Surfing the web means following hyperlinks to different web pages. As you surf around the web, you may find pages you have read about or seen mentioned on television.

Using the Browser

If you have gotten this far in your interest in the Internet, you probably have an online access, and can access the Internet on your PC. If this is the case, you are looking at the page on the Internet with a web browser. Just like any other software, a browser is just a tool, a special tool used for navigating and accessing information on the web. The browser's toolbar (a row of icons across the top of the page) shows the controls for navigating the web and managing the information you find there. The toolbar provides a range of detailed functions and commands for managing the browser. The address bar below the toolbar displays the current web site address being accessed. To go to a new web site, you type the site's web address (URL) directly into the white space on this bar. When you're finished typing, press Enter on your keyboard. Each web browser has some useful buttons on its toolbar, allowing access to features unique to itself, such as search engines and its own homepage and links.

Certain navigational features are common to all browsers:

1) Back and Forward buttons. The Back button returns you back to a previously displayed page, usually the most recent page. The Forward button returns you ahead to a previously displayed page. If you have not used the Back button in a current session, the Forward button will be inactive.
2) Open Start Page Button. The Open Start Page button returns you to your default start page. The start page is the page that you begin on when you open your browser.
3) Browser Logo. The "Browser" logo in the upper right corner of your screen moves as your browser accesses or downloads information. If the icon is moving for longer than you would like, use the Stop button described below.
4) Search Button. The Search button opens a page that contains Internet Search tools, such as *Alta Vista, Yahoo, Lycos, Incite, Savvy Search, and Infoseek.*
5) Stop Button. The Stop button immediately stops the browser from accessing a link.
6) Open and Add Bookmarks or Favorites. You can tell your browser to remember web pages that you would like to visit again by adding them to your bookmarks. You can always go back to any of these pages by using the bookmarks or favorites list. You can even organize your bookmarks into folders.

Doctors are by nature impatient and don't care to wait for a slow computer. That's why I suggested previously that you get the best equipment possible so that you won't be put off by long downloading waits (transferral of data from another computer to yours).

Internet servers allow many people to access a page at the same time. But not all

servers are equal, and some may not be able to keep up with the demands of many people's browser requests. If it seems to be taking a long time to load a page, be patient. It's not unusual for a page to take a while to access. If you try to access a page and see a dialog box that says it's unavailable or busy, treat it just like the busy signal on a telephone and try again later. Go on to something else on the Web.

Modem speed does make a difference; for surfing the web, you will want to use a modem that runs at a speed of at least 14.4 Kbps. The faster your modem, the less time it takes to load graphics and the more interactive the session can be. A 28.8 Kbps modem is more than twice as fast as a 14.4. The larger the file, the longer it will take to download to your browser. If you find yourself getting frustrated by slow connections, get a faster modem. It will improve the quality of your web surfing experience.

If the "moving" logo in the upper right corner of your browser toolbar is active for an unusually long time (longer than the time it takes to get a cup of coffee and return to your computer), use the Stop button to halt your request. There a rule of thumb for how long a page will take to download; it all depends on the speed of your modem, but in general, with a modem running at 14.4 Kbs it takes about 1 second to download every Kbyte of information. A 30 Kbyte file will take about 30 seconds.

Summary.

My goal has been to give you a basic understanding of the concepts involved with understanding and exploring the web. By this point you should know: what the Internet is, what the World Wide Web is, what a web site is, what a home page is, what a URL is, what a browser is, what hyperlinks are, and how to use your browser to surf the web. Problems that arise can usually be solved by going to the "Help" icon on your browser or going to the Web Tutorials that all browsers have on their software.

PART V
Creating a Homepage

If you have a PC (personal computer) and have been able to get onto the Internet and "surf the net" you've been seeing text and pictures (graphics) on"pages" on websites. More often than not these pages and websites were written by individuals who, like you, initially had little or no experience with computing. In this article I hope to give you some basic facts about building your own Home Page on the Internet. Websites can be personal, commercial or educational and can be placed on the Internet for many different reasons. Before you even consider getting a home page you need to decide why you want a page and what information you want to provide to the person accessing your website. This information is pretty much whatever you please but would be much more valuable if you had a definite message to deliver. The first page should be similar to an index or table of contents for the rest of your site, and should be relatively free of large graphics that are time-consuming to download If you desire to advertise your practice to the general public you would have a different message than if you were focusing on a group of doctors or specialists, and your page would need to reflect the difference in its content and format. These pages probably would be better constructed by a professional as you most likely would be able to use it as a business expense. Just simply building a web page for the "hell of it" is a lot more challenging and fun. It really is simple-even though when I first started I thought it to be one of the hardest things I've ever done – even harder than learning how to do a hernia repair properly. Here are some "anatomical facts" that you have to know and some "surgical instruments" that you'll have to have in order to perform this "operation".

Terms to Know

Default

A word that describes a setting on the computer, such as which printer, language, units of measure or a particular page that you have set as your home page — to which the computer returns every time. Unless you tell the computer otherwise, it goes by default to the preset position in your software.

WWW=World Wide Web

Web=World Wide Web

HTML=HyperText Markup Language

In practical terms, HTML is a collection of platform-independent styles (indicated by markup tags) that define the various components of a World Wide Web document. HTML was invented by Tim Berners-Lee while at CERN, the European Laboratory for Particle Physics in Geneva.

What an HTML Document Is

HTML documents are plain-text (also known as ASCII) files that can be created using any text editor (e.g., BBEdit on a Macintosh; Notepad on a Windows machine). You can also use word-processing software if you remember to save your document as "text only with line breaks."

HTML Editors

Some WYSIWYG (what you see is what you get) editors are available (e.g., Netscape Navigator Gold and HotMetal, which is available for several platforms or Adobe PageMill for Macintoshes). You may wish to try one of them after you learn some of the basics of HTML tagging. You might want to be able to code a document before diving into the WYSIWYG editors. If you haven't already selected your software, go to a search engine such as Alta Vista or Infoseek and get an online listing of HTML editors (organized by platform) to help you in your search for appropriate software.

Getting Your Files on a Server

If you have access to a Web server at your hospital or medical school or work, contact your webmaster (the individual who maintains the server) to see how you can get your files on the Web. If you do not have access to a server, check to see if your community operates a FreeNet, a community-based network that provides free access to the Internet. Lacking a FreeNet, you may need to contact a local Internet provider that will post your files on a server for a fee. (Check your local newspaper for advertisements or with your Chamber of Commerce for the names of companies.)

HTML is the language that the Internet recognizes and really is plain English in a specific format. HTML stands for "hypertext markup language" and is placed in a specific "htm" file. If you are unfamiliar with Hypertext Markup Language, you might want to explore HTML first.

Here are a few addresses where you can find this information:

http://www.ncsa.uiuc.edu/General/Internet/WWWMTMLPrimer.html

http://www.scsu-cs.ctstateu.edu/bikesh/html-help.html

http://home.mcom.com/home/services_docs/html-extensions.html

http://www.stars.com/Vlib/Providers/Forms.html

http://www.stars.com/Vlib/

http://www.yahoo.com/Computers/World_Wide_WebMTML/

http://www.w3.orglpublWWW/

Now stay with me while I try to explain "tags": An "element" is a basic component of the structure of a text document. Examples are heads, tables, paragraphs, and lists. Think of it this way: you use HTML tags to mark the elements of a file for your browser.

Elements can contain plain text, other elements, or both. To denote the various elements in an HTML document, you use tags. HTML tags consist of a left angle bracket (<), a tag name, and a right angle bracket (>). Tags are usually paired (e.g., <H1> and </H1>) to start and end the tag instruction. The end tag looks just like the start tag except a slash (/) precedes the text within the brackets.

Some elements may include an attribute, which is additional information that is included inside the start tag. For example, you can specify the alignment of images (top, middle, or bottom) by including the appropriate attribute with the image source HTML code.

NOTE: HTML is not case sensitive. <title> is equivalent to <TITLE> or <TiTlE>, and not all tags are supported by all World Wide Web browsers. If a browser does not support a tag, it (usually) just ignores it.

The Minimal HTML Document

Every HTML document should contain certain standard HTML tags. Each document consists of head and body text. The head contains the title, and the body contains the actual text that is made up of paragraphs, lists, and other elements. Browsers expect specific information because they are programmed according to HTML specifications.

Required elements are shown in this sample bare-bones document:

```
<html>

<head>

<TITLE>A Simple HTML Example</TITLE>

</head>

<body>

<H1>HTML is Easy To Learn</H1>

<P>Welcome to the world of HTML.

This is the first paragraph. While short it is

still a paragraph!</P>

<P>And this is the second paragraph.</P>

</body>

</html>
```

The required elements are the <html>, <head>, <title>, and <body> tags (and their corresponding end tags). Because you should include these tags in each file, you might want to create a template file (a file that is pre-formed) with

them. (Some browsers will format your HTML file correctly even if these tags are not included. But some browsers won't! So make sure to include them.)

Links

The chief power of HTML comes from its ability to link text and/or an image to another document or section of a document. A browser highlights the identified text or image with color and/or underlines to indicate that it is a hypertext link (often shortened to hyperlink or link). Clicking this link then carries you to that particular URL (with another page of HTML information).

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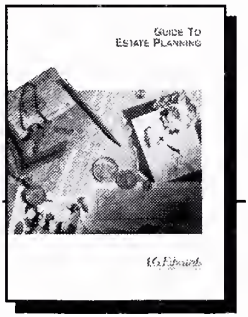

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"Surgical Instruments"

You need to have a personal computer, one with at least all the attributes that we talked about previously. If you don't remember, it needs to have a 486 or better processor, 16MB of RAM, 1+ gigabytes of storage and a fast modem (28.8bps or better). You need to be online with a "server" that can connect you to the Internet—preferably with a local agency for better backup service and help— and this server needs to be able to give you a specific URL, user name and password, and file to which to send your pages as you build them.

There's no need to purchase expensive software to create your home page, as web files can be typed into your Notepad facility in HTML, edited in HTML or you can modify someone else's homepage with material of your own. If you don't want to take the trouble to learn HTML, then there are several very good "browsers" that not only access the Internet but can write your pages for you in plain English. The two that I'm most familiar with are Netscape Navigator Gold and Microsoft's Internet Explorer and Internet Assistant/Microsoft Word.

Using these programs with a good ftp (file transfer protocol) you can rapidly become quite proficient in building your web site.

With Microsoft Word, you can use Internet Assistant for Word (downloaded free) to do the editing that needs to be done when you use someone else's page. It gives you all the editing facilities provided by Word and automatically produces all your documents in HTML when you finish. If you don't have Word, I'd suggest that you use Netscape's Navigator Gold 3.0, a program that you can download free on the Internet via Netscape's home page.

I have downloaded two good ftp programs (for free), Ws_ftp32 and Cutftp32; I use the latter more because of certain features that allow me to edit via my Notepad facility. This ftp program is the method by which you transfer data and pages from your computer to the server for transmission to the Internet. One has to be very careful to place all data and graphics in the appropriate file (index.html) and send it to the proper file (public_html) at the server computer.

Your server will probably give you 3-5 MB (megabytes) of disk space with your SLIP/PPP account when you join up. This will be where your Web pages will be stored. As I've said before, you can post anything you want on your pages (of course keeping it legal and non-defamatory); most people place resumes, photos and items of their own particular interest.

One way to learn more about HTML is to look at what others have done on their pages. You can do this by going to the "View Source" option and see how others do it. Once you have created your page, name it "index.html", save it as text-only, and send it by ftp into your personal directory that your server has set up for you. As you can see, there are many different ways in which to present your information.

One of the most frequently asked questions is: How do I make my documents really stand out? The best answer to this type of question is to: Browse through the WEB, looking at how others have done their home pages. When you find something that you think looks nice, look at the document source to see how they've done it. This is accomplished by Mosiac and Netscape using the " File - View Source".

As you surf through the Web you will find attractive photos and icons that you can download and save for use on your pages. Remember, however, that most

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of these images are copyrighted and should not be used without the permission of the owner. There are pages with lots of icons and these are free for your use. If you want to place your own photos on your pages, you can get a scanner or take your pictures to a photo shop, have them placed on a PhotoCD and transfer them to your computer via your CD Rom drive and used after converting them to .GIF and JPG formats.

Most of the online services like AOL give you a small personal page on which you can place your "Home page". This actually gives only basic information, allows no graphics and is little more than an address. The pleasure of building your own page is significant and the amount of material that you can transmit is much higher.

In this article we have skimmed the building of a simple web site (Home Page). Of course it can be much more involved and complicated than I have indicated, but this will give you a start toward gradually writing a web site that someone in Hong Kong might just find to be his/her cup of tea, not to mention the possibility that you might have informed someone of that one piece of information that they might have been looking for! All of us like to have our "15 minutes of fame" and probably all of us think we have something to teach or tell the world. I can think of no better way than the Internet to do just this!

Mrs. John O'Toole
A-MASA President

A TEAM... MEDICAL SOCIETY...

"A hundred years from now it will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove. But the world may be different because I was important in the life of a child."

Author unknown

I am honored to have the opportunity to serve as the 1996-97 Medical Alliance President. I believe what we do is very important. We are able to have an effect on people's lives at crucial stages that influence the rest of their lives. Let me tell you a true story of a little boy to show you how lack of this kind of help can really hurt

He remembers little of his childhood, but he does remember his father beating him and his mother when he got drunk. Then one night, he found out his Daddy got real drunk and was killed in a fight. **No one told them about drinking or abuse.** He remembers his sister getting pregnant and quitting school. **No one told her about sex or condoms or finishing school.** He remembers crying the nights they had no food or heat, but he didn't know that help was available. He remembers helping to raise his little sister's child, a severe asthmatic, along with his chain-smoking mother. **No one told him about cigarettes.** He remembers sadly finding out that his little brother was a drug addict, when the HIV test came back positive. He also remembers very well long nights working his way through school, not knowing that any kind of help was possible. **He remembers a lot of horrible things that happened because no one told them the dangers, no one offered any help and no one even told them help was available.**

A lot of the work we do as an Alliance can prevent at least some children from having the memories that my husband has to this day. These are things that my husband finds very difficult to share, but he wants you to know that it may have made a big difference if someone were there – like us – to help.

Let me tell you another true story about a woman named Nancy. I won't tell you what town she lives in but Nancy could have lived — or died— in any American city or town. And she very nearly did — thanks to Jim, who said he loved her, in spite of the fact that he beat the living daylights out of her. Nancy and her child finally managed to move out on their own —to safety. She even filed an Order Of

Protection against Jim. But it was just a paper tiger. Because on her own, Nancy couldn't afford a car or even a phone to call for help. And Jim and his abuse just kept coming. But then — Nancy did something more women should be able to do. Something that probably saved her life. She went down to her local police department and came away with a special cellular phone. It was pre-programmed to dial the sheriff's department, the police department and 911. It was part of a new phone-loaner program — for victims just like her. Not long after that, Nancy and her child were walking to buy groceries — when Jim stalked them on the open street. As he approached, Nancy hit the hot button on the cell phone. Jim took off running. In minutes, he was arrested — for violating the Order of Protection. But you know that this could have been a very different story—except for the fact that someone stepped in to fill the gap....between the help that was available, and the help that Nancy needed. That someone was a County Medical Alliance, who raised the money that purchased the loaner phones, which proved the critical link. This is a success story that's being repeated in every Alabama county where an Alliance is at work.

My husband's and Nancy's experiences stamp "urgent" across everything we do. It seems now, more than ever before, people sigh with frustration and helplessness, wondering how to cope with the ever-mushrooming problems tearing at our society's very fabric — violence, drugs, moral decay, AIDS, alcohol abuse, eating disorders, suicide, juvenile crime, runaways, child abuse. The statistics relating to youths and violence are grim:

—Nearly two million children are abused and neglected in the U.S. each year; 1000 die as a result.

—Homicide is among the five leading causes of death in childhood, with the majority of infant victims killed by parents, relatives or older children.

—Nine out of ten murders of children living in developed nations occur in the U.S.

—For black males age 15 to 24, homicide is the number one cause of death

—Between 1950 and 1990, the rate of adolescent suicide quadrupled.

Last year, our State Alliance distributed over 62,000 "Youth Survival" cards to 7th grade students throughout Alabama. This project was made possible through a joint effort with the Alabama Medical Society. The laminated card is imprinted with emergency 800 numbers for children to call for help in the areas of AIDS, alcohol abuse, child abuse, drug abuse, eating disorders, runaway, suicide and a crisis 9 line. By calling the 800 numbers they are connected with professional counselors who can assist them in any of these areas.

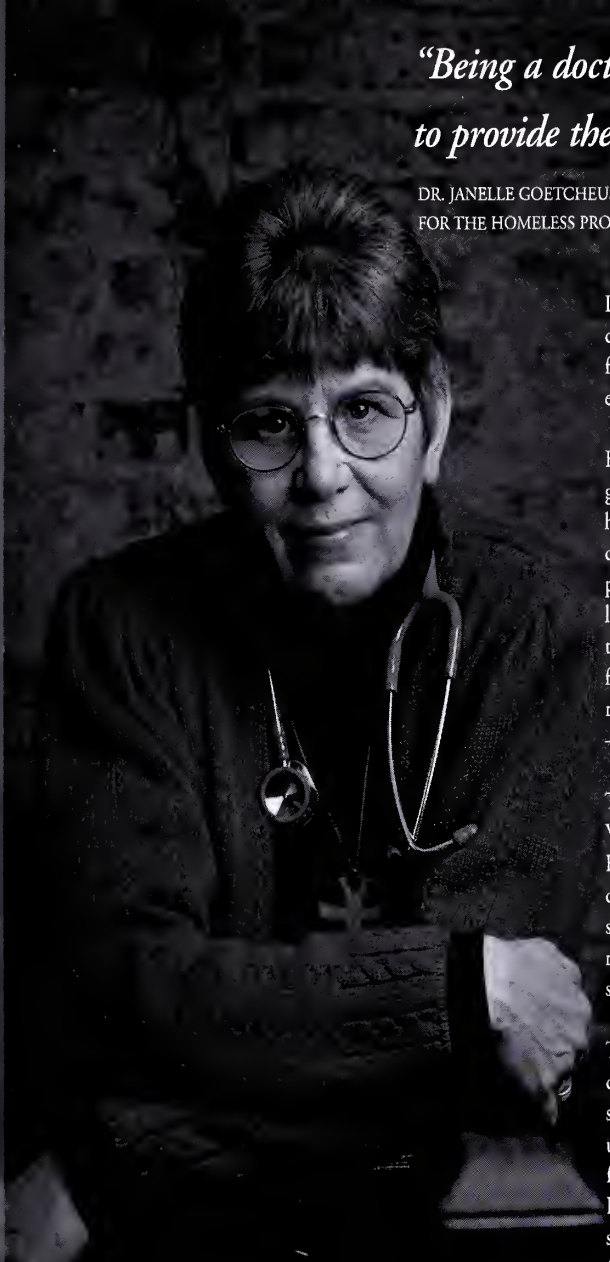
Our county Alliances contributed over $45,000 last year to the American Medical Association Education Research Foundation. Nationally, Alliances across the U.S. contributed over $1,384,000.00 to this foundation.

Our county Alliances sponsored programs and projects on sexual and physical abuse and raised thousands of dollars to support local family violence shelters. We, as Alliance members, are the voice for physicians and we are working very hard to show the community in which we live, the extent of the physician's concern for the health care needs of our state. Working together, we can speak with one voice to state and federal legislators through legislative contacts enabling members to respond quickly to issues, phone trees enhancing contact with members in key Congressional districts, and mini-internship programs to give legislators and community leaders a first-hand look at medical practice.

My goal, as President of the Alabama Medical Association Alliance, is to make every physician and physician spouse in this state aware of the important work that we do and encourage every spouse to support us through their membership in the alliance.

IT'S A FACT.... THE ALABAMA MEDICAL ASSOCIATION ALLIANCE works for you and your community, through health promotion and legislative efforts across our state.

Hand in Hand, we can touch the future and make a difference. ▼



"Being a doctor has allowed me to provide the best for my family."

DR. JANELLE GOETCHEUS, MEDICAL DIRECTOR, HEALTH CARE FOR THE HOMELESS PROJECT, INC., WASHINGTON, DC

Dr. Goetcheus says that raising her children in a health recovery facility for the homeless is one of the greatest gifts she has given them.

Her gifts to her patients are even greater. Caring for Washington's homeless for almost a decade, she despaired at seeing simple medical problems grow severe when patients lacked a clean, quiet place where they could heal. Her answer was to found Christ House, a live-in respite care facility for the homeless — and home to her family.

Today, this center is part of Washington's Health Care for the Homeless Project. As medical director of both, Dr. Goetcheus is serving in an even greater capacity, reviving health and hope in those she serves.

The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Health Care for the Homeless, in support of those who, like Dr. Goetcheus, are part of the cure.

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Vol. 1, No. 2, Winter 1997

MASA REVIEW

Incorporating **Alabama Medicine**,
The Journal of the Medical Association of the State of Alabama

Courtesy Reynolds Library, UAB

Doctor, have you felt like this lately? This woodcut from a medical text of 1517 depicted all the battle injuries of the period. But that was five centuries before managed care.

INSIDE...

FOUR MEDICAL LEGENDS...

CHAMP LYONS & TINSLEY HARRISON
OSLER & 'THE ALABAMA STUDENT'

ALSO...

•10 Caveats on Managed Care •The 1997 Medicare RBRVS and Conversion Factor Final Rules •The Lost Art of Handwashing • PRN Progress Report •Weaving the Web, a Physician's First Spin •What the Alliance Does for Physicians •Autism from the Patient's Viewpoint •The Heroism of a Paralyzed Golfer • Sundry Editorials

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In This Issue

Editorials, pages 4-10

• Reviewing **"The Yellow Brick Road:** Medicine as a Calling," Editor William A. Curry, M.D. , finds the lives of 32 doctors after medical school interesting but flawed by provincialism and parochialism.

• Brad Frisbie, M.D., the creator and webmaster of MASA's site, on the world wide web, brings to this work a background in engineering, philosophy and, of all things, chinchilla husbandry.

• Many physicians appear to be Internet-averse, but their patients have taken to some 25,000 health-related sites and the discussions are often well informed, according to one of their Pied Pipers, Tom Ferguson, M.D. of Harvard Medical School's Center for Clinical Computing. (**Online Healing**). Doctors who have been hesitant about testing the waters might be emboldened by "**Weaving the Web: A Physician's First Spin** by Medical Librarian Tomera P. Lee, page 45.

• And then there is a brief history (**Type Lice**) of typographical errors, which were around before Gutenberg.

If it's true that "the past is prologue," two articles on Medical Giants of the past may throw light on the present quandaries of physicians. Ernest S. Campbell, M.D., FACS, recalls the uncommon styles and influence of **Drs. Tinsley Harrison and Champ Lyons**, "two men whose personalities molded the shape of the Medical College of Alabama." Page 12. And a Canadian medical student, who, while an undergraduate at McGill University, became intrigued with **Sir William Osler's** discovery of the writings of **Dr. John Y. Bassett of Huntsville**. Dr. Osler brought posthumous fame to Dr. Bassett in his celebrated work, "**The Alabama Student**." Page 16.

A patient's view of autism from the inside looking out is recorded in as recent book, "**Thinking in Pictures**," reviewed by John R. Swallow, M.D., page 30.

Gerald L. Summer, M.D., Medical Director of MASA's **Physicians Recovery Network**, page 33, reports to the Board of Medical Examiners on the five years of his stewardship of the Alabama program for impaired physicians.

Rip Pfeifer, M.D., Mobile surgeon, with his gift of irony, offers a **Medical Quiz** on page 32.

A Tulane medical professor and a Birmingham medical office administrator collaborate in a highly valuable article, "**10 Caveats on Managed Care Contracting**," page 38.

Dr. Campbell's second offering in this issue is an important piece on the consequences of the decline in **handwashing**, page 50.

All you ever wanted to know about the "**1997 Medicare RBRVS and Conversion Factor Final Rules**" can be found in AMA's exhaustive white paper on the subject, page 55.

Mobile physician Stephen G. Lauten, M.D., writes of what he learned about courage and persistence from a **paralyzed golfer**. Page 61.

Finally, if you ever doubted the benefits physicians receive from **The Alliance**, Mrs. O'Toole's column, page 62, should be edifying.

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EDITORIALS

The Yellow Brick Road

Finding the Yellow Brick Road: Medicine as a Calling
Life After Medical School; 32 Doctors tell how they shaped their medical careers.
By Leonard Laster, M.D.
Norton, New York, 1996.
Reviewed by William A. Curry, M.D., F.A.C.P.

As physicians, how do we discern whatever sense of calling we may feel — whether to the profession as a whole, or to our particular segment of it? One description of a call is as the point of intersection of our joy and the world's need. It may have been that the author of *Life After Medical School* was exploring just such metaphysics when he conceived the format of this book: interviews with thirty-two physicians on widely different career paths, explaining how they came to choose their areas of work, and describing the joys, sorrows, challenges, and frustrations they encountered on the journey. "Follow your bliss," says Jeffrey Bernhard, an academic dermatologist and one of those interviewed. Considering the abundance of skin pathology in the world, those who find it blissful should be well on their way to fulfilling careers.

Life After Medical School enjoys some successes. It is realistic, in an unfiltered way. There is the sense of career-building by the seat of your pants, in a series of experiences and decisions that seemed important only after later reflection. Moreover, if two of life's Great Motivators are indeed Debt and The Fear of Debt, then these witnesses are credible. There is the flavor of eyewitness accounts, from a variety of specialties and from experiences that describe racism, sexism, and personal stresses.

For the medical student contemplating career choice (the apparent intended audience), there is some success in offering this group of witnesses. For the practicing physician, there is, understandably, something different. These divergent perspectives of the same activities and issues reveal the very different points of view that exist in modern medicine. They identify the same fault lines within the profession that we find in so many questions of policy and ethics. Here is a message for organized medicine: maybe we could be more effective if we understood each other better. At the same time, there is the satisfaction of hearing from physicians who, despite it all, are joining the needs of patients and their own satisfaction in ways that keep them working with at least some enthusiasm.

There are, however, some problems with this book. There is the

anecdotal style, which, frankly, is at times boring. The effort is largely unfocused; important conflicts are often too condensed and other matters too expansive for the reader to gain perspective. The content of most of the interviews is essentially "stream of consciousness" rather than the product of careful interview technique; there seems to have been a volley of softball questions and no probing followup. The results are lack of clarity and loss of proportion.

The single biggest problem, though, is the degree to which *Life After Medical School* suffers from a lack of diversity. The author is Chancellor Emeritus of the University of Massachusetts Medical Center, and most of those interviewed are faculty members of that institution. That they are from the Northeast, and that they are products of more elite colleges and medical schools, would not be problems if there were a balance of physicians from other regions and different backgrounds. Unfortunately, that balance is lacking, and the result is Northeastern provincialism.

Beyond provincialism, as Henry James observed of Thoreau, is parochialism. Only six of the thirty-two physicians in this book are engaged in the private practice of medicine. This, along with the lack of geographic diversity, seriously limits the variety of role models offered, especially for readers with different backgrounds and interests.

There is no substitute for good role models for students, and that has been recognized for a long time. Sir William Osler, in his characteristic classical style, put it this way: "Even in populous districts, the practice of medicine is a lonely road which winds uphill all the way, and a man may easily go astray and never reach the Delectable Mountains, unless he early finds those shepherd guides of whom Bunyan tells, Knowledge, Experience, Watchful, and Sincere." While there are useful perspectives within *Life After Medical School* for medical students and even for those long ago graduated, there is also the need for a broader effort. We could try a re-write, or perhaps we could look to Bunyan and Osler.

Webmaster Frisbie, M.D.

Imagine for a moment that you are the omniscient Human Resources Manager of a major multinational corporation. You have just begun to review the file of a prospective executive, otherwise unknown to you. You see that he earned three bachelor degrees in the mid-1980s: B.S. in Industrial Engineering and Management; B.S. in Biochemistry; and B.A. in Philosophy.

Without reading further, prove your mettle by plotting the trajectory of his professional life thereafter.

If your powers of inductive reasoning are finely honed, you would predict that the subject would have then been employed as an engineer for

the mammoth Hughes Corporation, redesigning machining processes and developing CAD-CAM software for robotic quality control devices in the production of precision mining equipment. You would also have figured, of course, that as an undergraduate he had developed software for hospital laboratories for the Kellog Foundation, and that he would have won high honors in an international contest for his paper on robotic programming.

Thus far, predicting the track of the subject is child's play, right? But fast forward to 1997. Without peeking, where is he now?

If you correctly calculated that after the above adventures, he would return to academe to study medicine and that he is now employed full-time as an Emergency Medicine Physician at Brookwood Medical Center, Birmingham, you are vouchsafed the best human resources director in the land. Any land.

Had you thrown in the educated guess that, even to this day, the subject hates the sight of chinchilla coats, and that one reason he settled here in the Deep South is to minimize such encounters, you have no peer in your field.

The subject is Bradley E. (Brad) Frisbie, M.D., World Wide Web project chairman and developer for the Association's website,

<http://www.masalink.org>

About those chinchillas: Dr. Frisbie is not of the animal rights fringe; his antipathy to their hides derives from his having played nanny to 300 chinchillas while attending medical school in Oklahoma. They were housed in a facility adjoining his digs. For his services in seeing to their creature comforts, principally feeding them and maintaining the frigid air conditioning so essential to their developing marketable coats, he was paid with free utilities, no small matter in a medical student's budget.

Casually dressed and laid back when he is not on duty in the ER, Dr. Frisbie, 36, could easily pass for one of the microserfs toiling to make Bill Gates richer still. His house is networked with computers on multiple platforms linked by Ethernet laced in the walls. He has computers humming along on just about every operating system: Unix, OS2 Warp, Windows 95 and Windows NT. Let him describe all the conveniences he has provided his wife (his claim, not hers):

"She can watch television on her computer, bank electronically, and when dinner is ready after watching a Betty Crocker Quicktime video clip on the computer next to the stove, she emails me, which immediately appears on whatever computer I'm on, which is more effective than yelling 'Dinner's ready!'" (Mrs. Frisbie was unavailable for comment.)

— William H. McDonald

Online Healing

What thousands of Americans like most about Tom Ferguson, M.D., senior associate at Harvard Medical School's Center for Clinical Computing, is the precise quality that many physicians find exasperating, if not downright infuriating: his blunt talk.

Since the 1970s, Dr. Ferguson has tried to change what he regards as a "creaky industrial age" health care system by empowering the patient with information. In an interview with *Wired* magazine for March, Dr. Ferguson was asked what really ails the U.S. health care system. His answer, thin in diplomacy, was characteristic:

"We rely on authoritarian professional care to solve nearly all of our health problems. Not only does this cost more than we can afford, it doesn't lead to the best quality care. The patient, the family, and informal self-help communities are probably the most important resources in health care, but they get very little press....

"Online networks bring the patient back into the loop. A lot of people think the Internet is for games, sex chat, and email to the sales team. What's health got to do with it? Plenty. The Web already has more than 25,000 health-related sites. You can search medical literature, access journal articles and medical textbooks, get a cookbook guide to essentials of diagnosing and treating just about any condition you want. AOL's Better Health & Medical Network alone gets more than 1 million hits a month. There are hundreds of mailing lists and Usenet newsgroups dedicated to health topics."

But, his interviewer asks, aren't these support groups "just victim cultures filled with mutual-pity parties?" Dr. Ferguson:

"It's much more robust than outsiders may imagine... An online support group lets you get your feelings out with no one judging you. People pay attention, and they don't interrupt. Often people will go to a depth of understanding that is quite overwhelming.."

But how can people trust the advice they get online?

"Some lay people know more about their condition than the professionals. If I am a Family Practitioner, I might need to know about maybe 1,000 different conditions. If a woman comes in with fibromyalgia, and she has spent the last three months researching the condition, it is very reasonable that she might know more about the condition than I do. Many times people in a discussion group have great breadth and range of knowledge on the topic and can give you the best current thinking. The information in these problem-specific online groups is generally much superior to anything you can find in any printed format and in many cases superior to anything you can get from your own health professional. "

But how about people who can't afford a computer and an Internet

connection? Dr. Ferguson answers that by pointing to the managed care entities that now provide a home health workstation "with 60 to 80 megabytes of high-quality information that is specific to your condition."

A modem links the patient to three different functions: one to talk with his/her own health professionals, another to connect with local community groups, and a third that enables the patient to talk with people with similar diagnoses who live nearby. It has been established, Dr. Ferguson says, that these patients require less clinical care. They are hospitalized for a shorter time, "plus their psychological well-being just goes right off the charts. . . their experience of being sick is an order of magnitude better because they are in charge."

Many doctors participate in online discussion groups, he says, but some can't adjust to the different role.

"Docs online can't take on the usual, all-knowing, calling-the-shots role. Do that and you'll get flamed. The social contract behind these online groups is that the patients and families own the group and the clinicians are guests. Docs are often surprised by how much they learn. Things that patients often don't tell doctors."

Finally, Dr. Ferguson was asked if doctors take to email? He answers:

"95% are terrified. They imagine a deluge from patients. The other 5%, mostly younger physicians, find that they can have more and higher quality interactions with their patients. You can talk to 50 people online via email in the time that you talk to five people on the phone. Docs can see the handwriting on the wall. They can see that the future of medicine is going to involve more online communication and that the people who become comfortable with it do it very well."

Author of a dozen self-help books, founder of *Medical Self-Care* magazine, he is perhaps the profession's more fervent advocate of cyberspace, a theme he developed in last year's book, *Health Online* (AddisonWesley).

In sum, Dr. Ferguson believes online medicine is the doctor's ally, not an interloper. An admitted internet zealot, he believes cyberspace will transform "the way we stay well, the way we heal, and the way we die." If you strongly agree or strongly disagree, he can be contacted in a couple of nanoseconds at drtomhi@aol.com.

— W. H. McD.

Type Lice

When Johann Gutenberg invented movable type in the 15th Century, he also mechanized the typographical error.

Before Gutenberg, the typo had always existed but since books were very expensive and scarce, being produced by laborious hand-copying in the monasteries (which also engaged in price-fixing), such goofs were not widely broadcast. Additionally, the monastic scribes enjoyed a certain clerical immunity from criticism by virtue of their holy office. They reproduced books chiefly in Latin, the language of scholars, and were thus insulated from the criticism of the masses. If forced by higher ecclesiastical authority to confess a mistake, they Latinized the grudging acknowledgment under the offputting label, *Erratum*, which is still in use.

Often, mistakes in a manuscript (*manuscriptum* translates "handwritten") were simply left there. Printers still use the Latinate "stet" to mean "let it stand." Multiple mistakes were, rarely, corrected on a full page of *Errata*, which enjoyed much the same protected status as the doctrine of Original Sin: an indelible, inescapable attribute of all mortal existence.

Well into our own century, it was fashionable to retain such a page as a depository of errors found in the final reading of a book after it was adjudged too late, or too expensive, to make corrections. When the wooden type of Gutenberg's day yielded in time to metal casting, printing had become scarcely different from other heavy industry. Great clanking, belching machines were fed molten type metal (an alloy of lead, antimony and tin) from steaming cauldrons in scenes that could have contributed to contemporary artists' conceptions of hell. The foundry noise, heat and general sweatshop conditions were closer to those of a boilermaking plant than to monastic serenity. In fact, the Church of Rome had earlier condemned the printing press as an instrument of the devil and succeeded in prohibiting its use in cities such as Paris for a quarter-century.

At some point in the evolution of the printed word, a nameless wag invented a mythical scapegoat for the typo. Errors were the work of "type lice," fiendish little creatures who invaded print shops in the still of the night and gnawed the errors. How else could mistakes that had escaped layers of writers and editors be explained? Type lice proved adaptable; they easily, and happily, made the transition to computer generated typesetting, beginning in the early 1970s. In fact, the computer's powers of replication may have enhanced their proliferation by an order of magnitude. There are even those who suspect that the infamous computer viruses and the much older type lice have entered into an evil synergy.

All of which is preface to a feeble explanation of the disaster area that was the table of contents in the Fall Issue of *MASA Review*. It appeared

to have been savaged by lice or virus, but alas it was all the product of human error. Our post mortem revealed what happened, but not how or why. Unaccountably, the contents page that reached the printer, Ovid Bell Press in Fulton, Missouri, was an earlier page which had been replaced by a corrected page. The page that went to press should have been consigned to the computer equivalent of the "hell box" of metal type days, a depository for dead type fated to be hauled to the smelter. Disastrously, the "saved" page was the flawed one and the corrected page got lost somewhere in the mysterious gut of the computer.

It was, in short, what printers have called "pied type" since the Middle Ages, a mass of hopelessly mixed type, a ghastly side effect of Herr Gutenberg's invention.. The term is of obscure origin but possibly related to the Latin "pica" or even, as some etymologists believe, the messy nest of the magpie. The error-riddled page was not discovered until a MASA secretary chanced to look at the final, revised magazine "dummy" one last time. By then, when the mess was discovered, the magazine was rolling on high-speed presses. Movies and plays to the contrary notwithstanding, "Stop the presses!" has never been heard even once by many lifelong journalists. The cost is prohibitive.

Gilb's Second Law of Reliability seems applicable: "At the source of every error which is blamed on the computer you will find at least two human errors, including the error of blaming it on the computer."

Guilty as charged.

— W. H. McD.

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Champ and Tinsley: Some Memories and Thoughts of Two Giants of Alabama Medicine

*by Ernest S. Campbell, M.D., FACS**
(divedoctor@earthlink.net)

They were obviously competing in the sense that they were like two bull moose contesting over the same turf but were respectful to each other in a courteous, cautious way. Each was a full professor and chairman of his respective department; one of surgery and the other of medicine; each was well known in his field of expertise, one writing extensively on the use of antibiotics in surgery, the other authoring a textbook of medicine. Their weekly contest centered on a jousting field consisting of a Saturday morning pathology conference about which were strewn the bones of lesser professors and staff who deigned to enter the fray. Of course, I'm talking about Dr. Champ Lyons and Dr. Tinsley Harrison, two men whose personalities molded the shape of the Medical College of Alabama in Birmingham, thrusting it screaming and kicking from the doldrums of WWII and the pre-antibiotic era into the mainstream of modern medicine.

Now, this conference was required attendance for the second-year medical students taking pathology, but was also eagerly attended by the third and fourth year students rotating through medicine and surgery, and pretty much a requirement for the medical and surgical house staff. Some students simply shrugged off their Friday night hangovers and wandered in to see the best show in town. This same conference was often used to showcase visiting professors such as Alton Oschner and Eugene Stead or Francis Moore or some other luminary from another medical school. It was at these times that the competition got the hottest between the two as to who was able to outdo the other with one upmanship.

Dr. Lyons, a personification of Theophrastus, bombastic and authoritative in his presentations, always seemed to have one or two references from the medical literature to back up his pronouncements. To the preclinical student, unfamiliar with the medical literature and maximally impressionable, he seemed to have a marvelous storehouse of information about all subjects even nonsurgical medical problems as they entered into the equation. In his debates with the pathologist presenting the morning case he would sarcastically use these quotes and devastate the case being presented, often leaving the pathologist confused and at a loss for words; and on one case that I can remember, near tears. Now, no self respecting pathologist would put up with this sort of treatment from a surgeon for very long and, as I recall, we went through several before a strong person was obtained — Dr. J.FA. McManus, who countered Dr. Lyons onslaught with courteous indifference.

On the other hand, Dr. Harrison was soft spoken, witty and rapier — like with his comments. He was always courteous, rarely sarcastic and seemed to have as his main goal the teaching of the medical student. In his

*Ono Island, AL

very carefully worded phrases he often skewered Dr. Lyons without him even realizing that he had been taken.

His respect for the family physician as the primary caretaker was legend and woe be unto him who referred to the local physician as an "LMD." He had a broad encyclopedic amount of information and rarely did one hear him refer to a reference in a journal, referring to work done by another as

Dr. Harrison was able to bring national and worldwide attention to the Medical College of Alabama

"personal communication." It was during these times in the early 1950's that he was making his first revision of his Textbook of Medicine and the data seemed to come out of his head as if from a computer.

Once, as a resident was presenting a patient to him in one of these conferences, the resident stated that the patients' "LMD" had done such and such and Dr. Harrison jumped to his feet, highly indignant and launched into an unusual tirade about the family doctor being the first bastion in medical care and how demeaning he felt the label "LMD" was to the long suffering, hard working local physician. Later on in the presentation, the resident related how the patient had been found to have a rectal mass upon examination at Jefferson Hillman Hospital and which had been missed by the referring doctor. Upon being told that the local physician had omitted the rectal exam, Dr. Harrison jumped up, apologized to the resident and said, "He really was an "LMD," wasn't he?"

All of us weren't as much in awe of Dr. Lyons as we were fearful. Some were downright disbelieving and one of my older Nu Sig fraternity brothers started to write down all of his references alluded to in his conferences. Checking these references in the library yielded what was suspected by most of us few came from bona fide articles but were generalizations of subjects by real authors, mixtures of articles written by others and some were not found at all. However, the basic information was rarely incorrect and as a teacher, he had done his job. We all felt a little less like a worm to find that our hero had clay feet. Of course, no one ever questioned him or brought this up to him in public and I doubt that anyone else has ever told this story.

Through his great teaching abilities, medical knowledge, prestige and cardiac research Dr. Harrison was able to bring national and worldwide attention to the Medical College of Alabama, now called University of Alabama in Birmingham. His textbook of medicine is familiar to all and has been a standard for many years. His method for organizing signs and symptoms has withstood the test of time, presaging the modern problem oriented medical record many years. His love for teaching continued for many years after he left academia and moved to Alex City, Alabama, where he kept up his contacts with students.

Dr. Lyons probably did just as much to advance medical care in Alabama but from an entirely different perspective. He was able and adept at obtaining funds and grant money from a federal government deep in the throes of a starting Medicare and Hill Burton Hospital Law. A close relative of Senator Hill from Alabama, Dr. Lyons was not shy about getting support for the medical school and was able to gener-

ous grant money to boost the quality of the teaching staff and programs at UAB.

Dr. Lyons also left a legacy which most people don't realize: the probable responsibility for the "Town and Gown" schism in the Birmingham medical community, still quite prominent in the largest city in the state. In the early fifties, there were many doctors and surgeons in Birmingham in private practice who participated in teaching as "clinical" professors. Family doctors and general practitioners used the old Jefferson Hillman facilities freely as one of their admitting and patient care resources as well as performing teaching duties and working in the charity clinics.

Beginning in 1957 and 1958, Dr. Lyons began a "weeding out" process, probably aimed at what he considered to be unqualified surgeons, but eventually including all non-certified clinicians. This immediately caused all the other hospitals in the city to become overloaded, often with constant 100% to 110% occupancy, and this process led to the terrible bed situation in the 1960s and 70s, and eventually to rampant competition between hospitals for state approval for more and more beds. One of the outcomes of this was the building of a new investor owned hospital, Brookwood, which eventually became the largest for-profit hospital in the United States. This only served to intensify the competition between other "non-profit" hospitals in the area, including the U.A.B. hospital system.

There is still a reluctance of Birmingham physicians in private practice to refer their patients to doctors at UAB, as excellent as their programs are. This is part of the legacy left by Dr. Lyons' actions in 1958, although now some of it is due to perceived poor treatment of referral doctors by the present physicians at UAB. This has been very hurtful to some patients, often causing delays in referral of problems that could be better diagnosed and treated at UAB, much to the detriment of the patient.

Building on the strong and dictatorial guidance of Dr. Lyons, the surgical residency program at UAB, although somewhat unheralded, is probably one of the best in the country. Without his early leadership it is doubtful that we would have the outstanding cardiac surgery program that Dr. John Kirklin was able to put together, a program that is undoubtedly one of the premier in the nation. Quick to grasp surgical advances as his own, he pushed his program to keep ahead and in so doing, developed surgeons with mental toughness as well as surgical skill, albeit often lacking in bedside charm. All of the surgeons from his program that I've personally known have been exceptional in their personal knowledge and ability — some I'd even let operate on me, possibly the highest recommendation another surgeon can give!

Similarly, Dr. Harrisons' residents are like a gene pool, propagating all over the southeast, practicing and teaching his type of medicine. Everywhere they go they carry some of his skills in diagnosis and a lot of his compassion in dealing with sick patients and frightened students.

I feel that I was fortunate to have been a student at the time that I could see these two giants of medicine and possibly have some of their "aura" rub off on me. Although not fortunate enough to have done my residency with either of these two men, I carry vivid memories of both as I'm sure do all touched by them who are now in practice over our state.

With contagion and death ever present in the 16th century, the danse macabre was a common theme. The Peddler, by Hans Holbein the Younger, 1538.

Dr. John Y. Bassett of Huntsville: Osler's 'Alabama Student'

Raghu Venugopal, BSc*

I wish to tell you the story of a man of whom you have never heard, whose name is not written on the scroll of fame, but of one who heard the call and forsook all and followed his ideal.[1]

I. Introduction:

One hundred years ago, one of America's leading physicians, William Osler, published a memorable series of biographical sketches. These sketches were later assembled into a volume entitled, *An Alabama Student and Other Biographical Essays*. Now, a century after An Alabama Student was written, it is appropriate to celebrate the life of one of the South's great medical heroes. In doing so, we must not forget *An Alabama Student* is beyond a classical myth purporting medical gallantry. It should serve, as it did a hundred years ago, to edify and remind the medical profession of its most important responsibilities. The key elements emphasized by Osler in *An Alabama Student* are the value of continued medical education, the ethos of humility and industry, and the virtue of journeying beyond one's own borders whether they are intellectual or geographical. The story of Dr. John Bassett, for its charm and professional instruction, should be retold to medical students and physicians who will hopefully find value and wisdom within it.

When Osler wrote *An Alabama Student*, he was Physician-in-Chief of the Johns Hopkins Hospital and held the Chair of Medicine at the Johns Hopkins Medical School. While there, he authored the famous textbook, *The Principles and Practice of Medicine* and was a leader in many fields including public health and the medical humanities. He catalyzed change within professional societies and zealously advocated the highest professional standards in medical practice.[2] In 1905, he crowned his career with the appointment of Regius Professor of Medicine at Oxford University, and in 1907, he was knighted by King George V. Sir William Osler maintained his position at Oxford until his death in 1919. To this day, Osler is a source of inspiration for generations of physicians and remains a topic of interest for numerous medical historians.

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An Alabama Student and Other Biographical Essays gained wide popularity during Osler's time and posthumously. His biographical essays were the favorite gift book of many physicians, including his famous biographer, *Harvey Cushing*.[3] On the flyleaves of the book, Osler wrote a dedication to William Welch, his friend and colleague at Johns Hopkins. In a theme reiterated throughout his essay of the *Alabama Student*, Osler paid homage to Welch for his "unselfish devotion to science [which] illustrates the spirit that in every age has made medicine of service to humanity."[1] Osler's medico-historical vignettes included giants in American medicine such as Harvard's Oliver Wendell Holmes and Pennsylvania's William Pepper. He penned sketches of classical medical heroes such as William Harvey, who elucidated the means of circulation, and Pierre Louis, who led the French school of medicine during the 19th century. Contained is also a devotional account of the 17th century physician, Sir Thomas Browne, Osler's own medical hero. Sir Thomas's book, *Medici Religio*, was Osler's favorite, and was a book he avidly collected in over 70 copies. At Osler's funeral at Christ Church Cathedral in England, his favorite copy of *Medici Religio* was placed by his side.

The most celebrated biography within this volume was that of the Alabama Student. Among the motley crew of medical greats, this was sketch of a man whom Osler believed was a silent pillar of medical science and medico-history. The physician referred to as the Alabama Student is Dr. John Y. Bassett of Huntsville, Alabama. According to Cushing, Osler decided to write about this Southern physician after fortuitously discovering Bassett's meticulous clinical work on malaria in January 1895. Among his many hats—such as neurologist and cardiologist—Osler, the epidemiologist, was captivated by infectious diseases as was Bassett. According to Cushing, "Though pegging away at this time at the first revision of his Textbook [*The Principles and Practice of Medicine*], [Osler] meanwhile found relaxation in other and more agreeable tasks. In this month of January two of his best biographical essays were presented before the Historical Society of the [Johns Hopkins Hospital]: one on Thomas Dover, Physician and Buccaneer [and] another entitled *An Alabama Student.*"[4]

Innumerable historical figures enchanted Osler, but he decisively chose to highlight this obscure rural physician to his academic colleagues. This was because there were many qualities of Bassett which fascinated Osler. The most important was that Bassett, although a physician by trade, had truly remained a student at heart. Osler was duly impressed by this as he had insisted all physicians must be perpetual students. He believed study was neither the perpetual duty of the researcher nor just the habit of the academic. Continual study for Osler was a pervading spirit essential in keeping the mind vigilant, the skills honed and the physician malleable to the inevitable change within the profession. Cushing gives a gleam of the

The world-renowned Dr. Osler elevated Dr. Bassett's name from obscurity to fame

delivery of Osler's speech and his reasons for choosing An Alabama Student,

"[Osler] gave a stirring and appreciative account of this unusual man, rescuing his story from among those forgotten and making him for all time one of the heroes of the 'medicine of the Southland,' an example to all young students of medicine, of what courage, persistence, and industry may accomplish in the face of difficulties and discouragements."[4]

This article builds upon Cushing's admiration of *An Alabama Student* and acquaints new practitioners of the value of Bassett's story. Osler's retelling will be only outlined. In addition, the article will give the reader essential principles which Osler wanted all practitioners — from North and South — to develop in order to preserve the living legacy of John Bassett.

II William Osler's description of Dr. John Bassett:

In *An Alabama Student*, Osler reveals a physician who dedicated much of his life towards the medical profession's goals. Bassett's sacrifices for the profession impressed Osler so much that he compared him to the Sunnyasi of Hinduism who dedicates his entire life to the service of God. In Osler's words,

"In varied tones to all, at one time or another, the call comes; to one, to forsake all and follow Him; to another, to scorn delights and live the laborious days of a student; to the third, to renounce all in the life of a Sunnyasi in the words which we know better, 'Many are called, but few are chosen'."[1]

Osler knew well the devotion of both student and religious man as each were early testing grounds for him. As an incessant student, Osler remained to his dying days. In his early student life, Osler began to love science by collecting pond water near his home in Bond Head, Ontario, to analyze under his microscope. Nearing the end of life, Osler kept reading and writing at a steady pace and quietly wished he could attend his own autopsy as a student-observer! After his death, as a

'In varied tones to all, at one time or another, the call comes...'

Student of Christ Church College at Oxford University, his funeral was held among his many friends and family. After the funeral, Osler's ashes were encased behind a secret panel at the McGill University library which would bear his name, and which was dedicated for the study of the History of Medicine. It should be noted Osler almost chose to follow the calling of the Church, as an Anglican Minister like his father, at the University of Toronto. However, the natural sciences interested him so much he decided medicine would be a better calling in life, and so pursued it instead.

In *The Life of Sir William Osler*, it is revealed that Osler chanced upon Bassett's fascinating life while reading of Southern infectious diseases in Fenner's *Southern Medical Reports* of 1849-51.[4] With his discovery of Bassett, these reports soon became the grist of Osler's literary mill. Little wonder should exist why Osler was reading about malaria plaguing a por-

tion of the county he had little contact with and in a publication printed 45 years earlier. For such infectious diseases, including tuberculosis, also plagued the northern cities of Philadelphia and Washington in Osler's time. In addition, as a teacher of future physicians, Osler taught his students to be well-read and to read widely, and evidently he practiced what he preached by reading articles such as Bassett's. Osler wrote of his investigation of John Bassett,

"I was particularly impressed with two by Dr. John Y. Bassett, of Huntsville, Alabama, in whom I seemed to recognize a 'likeness to the wise below: a kindred with the great of old'....There are a few men in every community who, from temperament or conviction, cannot bow to the Baals of the society about them, and who stand aloof, in thought at least, from the common herd. Such men tread a steep and thorny road, and of such in all ages has the race delighted to make its martyrs."[1]

Dr. Bassett had to endure otracism at home because of his European quest

Osler felt Bassett's letters indicated he was restless and non-conforming. He was not a routine physician who learned enough in medical school to pass off as a physician and who then ceased learning to follow more lucrative pursuits. Bassett was special. He lacked hollowness and deceit contained in much of the life around him. He was deeply motivated to advance medicine and to learn from the profession's influential leaders. In a world without modern advancements which link a student with huge banks of information, Bassett realized he must travel far in order to satiate his need for knowledge,

"As a student he had doubtless felt a glow of enthusiasm at the rapid development of the science of medicine, and amid the worries and vexations of a country practice his heart burned with the hope of visiting the great centres of learning." [1]

A short note is deserved about the rich medical background which surrounded the Alabama Student. The main influence of early to middle 19th century health care was the French school of medicine based in Paris. Until the rise of German medicine, French medicine was the pinnacle of the profession. Their school broke away from traditional medical practice which favored heroic therapeutic drug doses and physician intervention for the smallest illness imaginable. The French school placed great emphasis on the clinical description of disease and observation of the natural processes of disease. As a result of such methods, during a large period of the 19th century, Paris flourished as the Mecca of medicine. There, the art of making a differential diagnosis was developed and systematized. Symptoms, signs and outward lesions of disease were linked with postmortem structural and internal lesions of organs or formerly inaccessible body parts. Key among such advances was the dissection of human material, which before was faced with revulsion by the Church and medical laity. Between the years 1836-1851, with the backdrop being the rise in French medicine, Osler described the European journeys of John Bassett.

III. John Bassett's decision to travel to Europe:

According to his correspondence from 1830-50, Bassett left his profitable medical practice, his wife and his children to go to Europe. He departed to study under the foremost medical teachers of the 19th century: Laennec, Louis, and Velpeau. In the mid-1800s, Bassett's actions caused alarm within his community and family. Numerous apologetic letters from Europe were written by Bassett to his wife. In those, he urged his wife to endure mounting ostracism by locals due to his presumed family abandonment. In retrospect we know Bassett had no intention of shirking his responsibilities. In fact, when he returned from his sojourn, with new skills and a better education, he accumulated a more lucrative medical practice and became the foremost surgeon in northern Alabama.[5]

Osler was sympathetic to Bassett's calling, as he too, in different circumstances, experienced a craving for excursion and rumination. As a medical graduate and later, as a sectarian medical educator, Osler made pilgrimages to the medical clinics of Europe. As a result of his experiences, Osler expounded, through example and text, the value of rejuvenating trips at regular intervals during the career of all physicians. Osler wrote in his essay, *The Student Life*, that with a sacred hunger for medicine and proper preliminary training, the medical practitioner needed only three things to stimulate and sustain his education. These indispensable ingredients were a well-used notebook, a well-endowed library and a quinquennial brain-dusting.[6]

Despite resistance inhibiting Bassett from traveling, he departed nonetheless with no small amount of bitterness left behind. In Europe, he fulfilled his lifelong dreams as he continued his medical education in a meaningful and beneficial manner. He studied among the best clinicians in the western world. After observing medical practice in York, Edinburgh, Glasgow, Belfast, Dublin and London, he took passage to his ultimate goal, Paris. There, he worked with Velpeau at La Charite Hospital. Oslerians will not be surprised. Osler whimsically hoped that although, "[Bassett] did not mention their names....it is pleasant to think he may have attended classes at La Pitie with Bowditch, Holmes, Shattuck, Gerhard, and Stille"[1] — all future heroes of American medicine. A romantic notion on one hand, yet perfectly possible on the other, as the foremost in medicine were trained in and around Paris at the time.

In France, Bassett was delighted that hospitals were run liberally, allowing visitors like him to join lectures and clinics. Unlike in the United States or Canada, there apparently were great "opportunities for dissection." Of his daily schedule, Bassett wrote,

Dr. Bassett's pursuit of his dreams took him to Edinburgh, Glasgow, Belfast, London and, finally, Paris

"I get up in the morning at six o'clock and am at La Charite by seven, follow Velpeau until eight, see him operate and lecture until after nine, breakfast at ten at a cafe. At eleven I am at a school of practical anatomy, where I dissect until two. Then I attend a class of practical surgery until three;

then hear Broussais and Andral until five; then dine. At seven I attend Helmagrande's class of midwifery, which lasts until nine; then I come to my room and read until nine; or write until eleven, when I retire." [1]

As indicated, Bassett had unlimited access to study and human dissection. The latter was due to raging hospital infections and unbridled contagions. Sanitary conditions, or the lack thereof, quickly felled surgical patients. Since Lister's antisepsis methods were not yet elucidated, physicians regularly worked in the morgue and operating room without as much as washing their hands. The hospital in 19th century France was a last resort for the traveler or destitute, and the lucky ones who could afford better care were treated at home by private physicians. The macabre patients at La Pitie often bade Bassett adieu, or good-bye — knowing they would meet soon enough for further examination by Bassett upon his dissection table. At La Pitie, Bassett was instructed on the use of medicine's newest advancements, including the stethoscope.

Eventually Bassett was made an "externe," which was unpaid post, but which brought greater patient responsibilities and hospital duties. Rather than the elevated status, it was Bassett's modest attitude which impressed Osler. Osler felt the humility explicit in Bassett's letters was an example to all medical students, investigators and practitioners alike. A good example to complement Bassett is Osler himself as numerous vignettes illustrate him as a person never worried about the length of his shadow or as too important to help the younger generation succeed. With his relatively small promotion Bassett wrote,

"I was on the eve of starting for Switzerland....but when this offer [as externe] was made [to] me I did what I have been doing all my life—made another sacrifice for my profession, and determined to remain to take up the service. I have not been more gratified since I have been in Europe; it is a real benefit and came unsolicited." [1]

The predicament of Bassett, in which he had to choose between his own benefit and the profession's, was

Dr. Osler, beginning to tire, accepts an Oxford appointment

also common to Osler. For rather than relaxing in spare time, Osler would organize a round of subscriptions to aid the Maryland Faculty of Medicine or join a committee to oversee university reform. Eventually, due to Osler's voluminous professional work and various efforts to improve the profession in America, his stamina began to wane in the early 1900s. Thus, in 1905, he considered his own welfare and accepted the Regius Professorship at Oxford University—a post with little teaching or clinical duties. Yet even this self-promotion was not without coaxing. Osler's wife, Grace Revere, sternly cabled her husband when the Oxford news broke stating, "Do not delay. Accept at once." Apparently, she felt it was better to be shipped to England as soon as possible in good health rather than later in a pine box! [4]

An Alabama Student is loyal to Osler's innermost feelings, as it shows his admiration for the French medical establishment and his adoration for its

emphasis on the never-ending process of learning. Bassett wrote himself,

"When I look at some of the medical men by whom I am surrounded, it makes me blush for shame; old men daily may be seen mixing their white locks with boys, and pursuing their profession with the ardour of youth. There is not a solitary man in France that is idle, for if he was, at that moment he would be outstripped."

How closely Osler himself admired the European zeal for learning and their investigative spirit was demonstrated almost 60 years after Bassett's time. While Osler and friends toured the laboratories and clinics of Germany as part of his own brain-dusting trip, it has been found he wrote almost duplicate letters as Bassett, except Osler's letters were serial and addressed to each of his house physicians at the Johns Hopkins Hospital. Osler wrote to Dr. August Hoch with great excitement,

"The universities of Germany are her chief glory, and the greatest boon she can give to us in the New World is to return our young men infected with the spirit of earnestness and with the love of thoroughness which characterizes the work done in them."[4]

Another reason Osler chose Bassett's story was because, during Osler's time, the French tradition of medicine was a school under siege. As Osler encountered the first Johns Hopkins medical school classes, their curriculum was vastly different from that he had experienced. The Hopkins curriculum was unlike others in most parts of the United States or Canada. Unprecedented emphasis lay on laboratory medicine and basic research, in addition to traditional patient contact. With research-oriented physicians such as William Welch, medical investigation became the institution's third pillar alongside patient care and medical teaching. Medical graduates from Hopkins were recruited into positions which divided time between research and patient care. Changes at Hopkins alarmed numerous medical laity and physicians around the country. They felt a new generation of physicians was being created which was too removed from traditional patient care. None the least of those worried was Osler. As a result of the encroachment of technology on the practice of medicine, Osler worked to prevent a new breed of student-practitioners who would only be laboratory "prigs".[7] Osler was active in this sense through his own example as one who balanced investigation, teaching and patient care, and he has since been canonized for his efforts. *An Alabama Student* is a further testament for physicians not to lose sight of the importance of the clinical duties which were first mastered by the French to the research-oriented emphasis of the German school of medicine.

Overall, Osler's narrative is a refutation of medicine's movement away from the French school of clinical expertise to the German school, which stressed laboratory and basic investigation. Although Osler was a great proponent of German leadership in medical science in the 1890s, he nonetheless sought — with Bassett's example — to rekindle the best of the French school of medicine. The value of *An Alabama Student* is its concern for issues still haunting us today. Few disagree that the attraction of holistic and alternative healers, like American physician Deepak Chopra, is due to the often mechanical and impersonal nature of contemporary medicine. Alternative medicine's harnessing of

both spirit and mind in treating patients recognizes "there is no magic bullet in the form of a pill" to cure disease.[8] A century after Osler's time, the struggle of the medical school to determine how much of the science and art of medicine student practitioners should learn is still alive. Movements to balance investigation, patient care and continued medical education aptly reflect the call of Osler to his colleagues and students to pay heed to the benefits of both the French and German schools of medicine.

IV. Bassett's return to America and his Medical Reports:

When Bassett Ended his European trip, he told his wife, "I am glad I know what great men are. I am glad I know of what they are made, and how they made themselves great."[1] In Bassett's case, he was referring to the investigative spirit and drive for knowledge among the Europeans discovering new and unknown facts about the human body. Osler too, acknowledged such greatness, but also found another type, a quieter one, in Bassett. The Alabama Student's virtues lay in his bravery to follow his inner beliefs, regardless of how ridiculous they sounded to others, and his professional ethic which made him an ideal physician. Simple greatness made Bassett as celebrated as the scientific genius of Charcot, Koch or Lister in the mind's eye of Osler.

After his European travels, Bassett returned to Huntsville and resumed practicing. His practice grew and he built a beautiful home in Huntsville, which generations of Bassetts have since made their residence. He was a vocal opponent of slavery and was heavily involved in organizing the Medical Society of Madison County, as its secretary and chairman. Bassett also published two articles in Fenner's *Southern Medical Reports,* and of those reports Osler concluded,

"The two papers in Fenner's....are the only ones I see credited to him. They are charmingly written and display in every page the wise physician; wise not only with the wisdom of the schools, but with that deeper knowledge of the even-balanced soul who 'saw life steadily and saw it whole'.[1]

Osler paints a well-tempered general practitioner, who keenly followed the scientific advances of Europe and also was a cultured writer. Bassett's style conjured many biblical allusions and classical references. Osler's own style was similar to Bassett's, as he also peppered his papers and speeches with literary allusions. In Bassett's description of the effect of scarlet fever in 1833, he illustrates how deceased children often remained under the same roof as those still alive,

"I feel certain that this was a most malignant disease; but I do not feel certain that in every case our best physicians remembered the united

'Nothing does good but may also hurt'

counsel of Hippocrates and Ovid, that 'nothing does good but what may also hurt', and which should never be lost sight of by the man of medicine."[1]

Many such sagacious lines led Osler to believe Bassett had a well-equipped library with "references to authors both old and new [which were]

not only full, but most appropriate." In a graceful manner, Bassett reported cases of smallpox epidemics and embroiled debates over the use of anaesthetics in labour. Evidently,

Osler found he could speak through Bassett

Bassett fought vigorously in the 1840s for the use of anaesthetics as Osler did against the medical laity campaign of the 1890s which opposed human experimentation. Both felt it was humiliating for science to wait for the "dullness of the clergy" and other such sources to proceed with medical experimentation which would not only ease suffering, but save human lives. Both physicians were neither politicians nor lobbyists, but were concerned with advancing medicine through scientific study.

Bassett, like Osler, was skeptical of heroic therapies and cure-alls. Many have wrongly written that Osler was a therapeutic nihilist, but that has been soundly proven incorrect.[9] Bassett, like Osler, realized the vast mysteries of Nature and the meager knowledge mankind had of the human body. Bassett warned his Southern medical colleagues to allow Nature to take its course before prescribing drugs, and to respect Nature's power over the Hippocratic medical tradition. In his words,

"Hippocrates was but our fellow servant, and we are but ministers of Nature; our whole art consists in understanding her languages and laws; our whole practice, in obeying her mandates: if we do not understand them, it is either our fault or misfortune; to act as though we did is quackery."[1]

Bassett deplored the practice of irregular physicians, homeopaths, and unabashed quacks in the South. He also cast doubt on the unnecessary use of strong purgatives, laxatives, and cure-alls like calomel, quinine and cod-liver oil by both regular physicians and irregular healers. Bassett's beliefs are strongly echoed by Osler, who in his famous textbook, *The Principles and Practice of Medicine,* chided the perfunctory prescription of drugs and medicines. He rather preferred to use minimal drugs, maximal patient encouragement and to allow Nature to take its course whenever possible.

Beyond Bassett's warnings of quackery, he grappled with the essential philosophies behind the entire practice of medicine. As can be seen, this delighted the medico-philosopher in Osler, as he left out his own impressions on the topic to instead speak through Bassett's. Osler's only preface was, "Rarely has the credo of a zealous physician been more beautifully expressed." Bassett wrote that the study of medicine simply amounted to the learning of a new language. Once the physician felt master of part of the language—say, human anatomy—Bassett encouraged the student,

"[to] go into [the language's] native country and attempt to use it among the polite and well-informed; if he succeed, let him go among the illiterate and rude into the lunatic asylum, where the vernacular is babbled in broken sentences through the mouth of an idiot. Should he again succeed, he may safely say that he knows that language. Let him then set down and calculate the cost, in labour, time, and talent;

then square this amount and go boldly into the [next] study of physiology..."[1]

Apparently, once the student reached the "temple" of physiological study, he would humbly knock at its door and realize the "open sesame" of the profession. In other words, once the physician was properly trained in physiology he would be admitted inside the temple of the body and be "dumb-struck by its beauty and intricacy. After having mastered physiology, Bassett's ideal student would,

"be led to his ultimate object, to take his last lessons from the poor and the suffering, the fevered and the phrenzied...into the pest-houses and prisons, and here, in these magazines of misery and contagion he must not only take up his abode, but following the example of his Divine Master, he must love to dwell there;—this is Pathology."

By finding such lines in a lost journal, it is no wonder the kindred heart of Osler was captured. Also, since Osler was a distinguished pathologist after his post-graduate days at McGill, he could appreciate the graded learning of anatomy, physiology and pathology— and the philosophical bent applied by the author. Bassett concluded the training of the ideal student when he,

"...re-enters the world, a physician; his vast labours have not only taught him how little he knows, but that he knows this little well. Conscious of this virtue, he feels no necessity of trumpeting his professional acquirements abroad, but with becoming modesty and true dignity, which constitute genuine professional pride, he leaves this to the good sense of his fellow citizens to discover."

Such lines wonder-struck Osler when he unexpectedly found them. No wonder he retold Bassett's story to America and Europe for they radiate the professional values Osler spent a lifetime professing. Following the publishing of *An Alabama Student,* it was immensely popular. It was a common sight at Osler's Oxford home (dubbed the "Open Arms" because of its gracious hospitality) for admirers to bring copies of the book for the Regius Professor to autograph. Osler ends the story of the *Alabama Student* with Bassett's death on November 2nd, 1851, in Huntsville. Bassett died, at age 46, and it was believed due to complications arising from tuberculosis.

V. Effects of William Osler's work on the life of Dr. John Y. Bassett:

Following the attention which Osler drew to the *Alabama Student*, the publisher, Charles C. Thomas, rekindled Bassett's medical reports by reprinting them. The task was led by Daniel C. Elkin, who in 1940 wrote,

"A series of fortuitous circumstances rescued John Y. Bassett from the oblivion to which he seemed otherwise doomed. Osler, in looking over the literature of malarial fevers, chanced on Bassett's articles....He was so fascinated by the charm of these philosophical essays that he set about to piece together his life....The result was....the most delightful and popular of Osler's many biographical excursions."[3]

Fenner's *Southern Medical Reports*, where Bassett published his work, was an ill-fated publication after two years due to inadequate financial support. Despite the instability of the future of *Southern Medical Reports,* Bassett chose to publish his work within it. It is suggested Bassett's reasons

for doing so were because the *Medical Reports* represented his long-hoped for chance to air his philosophies, his love of truth, and his hatred of hypocrisy. Bassett finally had the proper venue to criticize quackery so that the local community would take notice. The *Medical Reports* also gave him an occasion to include his personal credo regarding the role of medicine and physicians.[3]

Osler's vignette of the *Alabama Student* was not only popular among his medical contemporaries and younger colleagues such as Harvey Cushing. The *Alabama Student* also

'To have striven, to have made an effort, to have been true to certain ideals — this alone is worth the struggle'

elicited praise from members of Southern communities and even Bassett's daughter, Laura, of Huntsville. Laura Bassett, who while in Paris in 1836, was the relative who sent Osler a bundle of letters written by Bassett to his wife. These letters later became the basis of Osler's essay. After the publishing of Bassett's story in the *Johns Hopkins Hospital Bulletin*, prior to the publishing of *An Alabama Student And Other Biographical Essays*, Laura Bassett wrote a letter to Osler praising his work on her father's life. In other correspondence between Laura Bassett and Osler, she requested a photo of him. After comparing the photo to her imagined likeness of Osler she wrote back to him,

"You have a different look from what I had imagined and I have not done you justice in any respect, except from an intellectual standpoint. The rotund, baldheaded, eagle-eyed and [eagle]-nosed Dr., with a slightly dictatorial manner now gives way before the real and true picture."[4]

VI. William Osler's examination of the life of Dr. John Y. Bassett:

Parallels are easily drawn between the lives of Osler and Bassett. Both advocated industry among student-practitioners and the organization of the medical profession. Both also encouraged the appreciation of humanities and disciplines outside the sphere of medicine, and the benefits of travel abroad. Most importantly, both staunchly supported continuing medical education, a concept divided into four pillars by Osler in his essay "Teacher and Student." These principles remain the basic intellectual and moral habits which medical students are expected to master and practice throughout their careers, and have been well-enunciated by Wallis.[2] The first principle was "The Art of Detachment" whereby students possessed self-discipline to avoid distraction from the important tasks of learning and healing. Secondly, "The Virtue of Method" was espoused as the need to prioritize duties and to spend time wisely — in either work, rest, or hobby. Next, "The Quality of Thoroughness" was the necessity to tackle work and study with exactness and exhaustive scrutiny as expounded by the scientific method. Lastly, "The Grace of Humility" was believed to be key in continuing one's education. Neither Bassett nor Osler was satisfied they knew enough to cease being a student. Both were humble about their knowledge, and always felt there was

more about medicine they could learn. With such a dose of humility, continuing education is but a must.

In short, Osler was astonished to discover the Alabama Student, for his panoramic analysis of many issues could have easily been buried within the mass of medical literature. Realizing this, Osler poignantly concluded *An Alabama Student* by noting, "The saddest lament in Oliver Wendell Holmes's poems is for the voiceless, 'for those who never sing, But die with all their music in them.' Dr. Bassett [was]....a man of more than ordinary gifts, but he was among the voiceless of the profession. Nowadays environment, opportunity, chance, carry men to the summit. To those restless spirits who have had ambition without opportunities, and ideals not realizable in the world in which they move, the story of his life may be a solace."[1]

Even at the peak of Bassett's career in Paris, when he was moving within the circle of teachers like Velpeau, Andral, and Broussais, there is no record or lasting impression of his achievements. In addition, his teachers leave no lasting legacy in medical history, unlike those Osler moved among like Lista, Koch and Horsely. The European experiences of Bassett have not been celebrated as Osler's, and quite frankly, Osler wrote, "To-day scarcely one of those he mentions touches us with any firmness from the past."[1] Thus, what lesson is to be learned from Osler's reaffirmation of Bassett's life? What motive was behind Osler's casting of John Bassett as the flag-bearer of his collection of famous biographies? The best answer is found in Osler's words,

"To have striven, to have made an effort, to have been true to certain ideals—this alone is worth the struggle."[1] In other words, whether Bassett, or his teachers, became household names in medicine or made great advances is irrelevant compared to their sincere efforts to adhere to the principles of continued education as physicians and their continued pursuit of knowledge to advance the care of patients.

The memory and spirit of the *Alabama Student* is a living heritage among the medical profession in Alabama and among all students of Aesclepius. For in Bassett can be found many of medicine's highest ideals. Such ideals are also found in Osler, whose story has been partly told here. Within the history of both Bassett and Osler, there is much to learn for the medical student in letter and the student still at heart. Osler ends his sketch of John Bassett with the following lines from an unidentified poem:

No one asks
Who or what we have been,
More than he asks what waves,
In the moonlit solitudes mild
Of the midmost ocean,
have swelled,
Foam'd for a moment, and gone.

Acknowledgements

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References

1. Osler W. "An Alabama Student." An Alabama Student and Other Biographical Essays. New York: Oxford University Press,

American Branch, 1909.

2. Wallis F. Continuing Education as Ethical Imperative: Listening afresh to Sir William Osler. Transactions of the Royal Society of Canada. Ottawa; Sakes VL 3: 87-97.

3. Elfin DC. The Medical Reports of John Y. Bassett, M.D. The Alabama Student. Springfield, Illinois: Charles C. Thomas, 1941.

4. Cushing H.W. The Life of Sir William Osler. Toronto: Oxford at the Clarandon Press, 1925.

5. Carmichael EB. John Young Bassett, The Alabama Student. Journal of the Medical Association of the State of Alabama. Montgomery; 34: 30-35.

6. Osler W. "The Student Life." Aequanimitas. With other Addresses to Medical Students, Nurses and Practitioners of Medicine. New York: The Blakiston Company, 1953.

7. Osler W. "On Whole-Time Clinical Teaching in Medical Schools." Wm. Osler: The Continuing Education. Eds. McGovern, J.P., Roland, C.G. United States of America: Charles C. Thomas, Publisher, 1969.

8. Chopra D. World Wide Web Homepage. www.doubleclickd.com/chopra.html homepage, 1996.

9. Macht DI. Osler's Prescriptions and Matilda Medical Osler Library Newsletter. Montreal; June 1994, 76: 1-5.

10. Osler W. "Teacher and Student." Aequanimitas. With other Addresses to Medical Students, Nurses and Practitioners of Medicine. New York: The Blakiston Company, 1953.

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In this 1524 engraving a barber surgeon operates on a peasant with no visible concern for pain or pathogens.

Autism: A Patient's View

Thinking In Pictures, And Other Reports From My Life With Autism
By Temple Grandin, PhD.
Vintage Books, a division of Random House, Inc., 1996
Reviewed by John R. Swallow, M.D..

Having an illness whose core features are a deficit in the ability to communicate, deficits in social interactions, and a limited range of interests do not sound like qualifications for writing the latest best-selling novel. Luckily, Dr. Temple Grandin does not attempt to write a book for the reader, but gives a raw and relatively unedited account of the inner workings of her mind, an autistic mind.

The result in an opportunity to understand autism in a way that has never been possible for most clinicians. Dr. Grandin is a remarkable individual who has high functioning autism, but at the same time has been able to get a Ph.D in animal science and explain, perhaps better than has ever been described before, how autistic people think. Dr Grandin reports that she has almost no verbal memory at all, the kind of memory most people use. Instead, she is like a living, digital video recorder, and gives a fascinating account of how she literally thinks in pictures. While there are obvious problems with this, Dr. Grandin has been able to use this to her advantage, and is one of the world's leaders in designing animal handling and processing plants. She claims that she can think like an animal because of her visual memory.

It appears that Dr. Grandin has spent most of her life reading, because her range of knowledge is encyclopedic. Getting a chance to peer inside the mind of a genius was a humbling experience, and was like nothing I have ever read before. Reading this took is a jarring experience, because it it a bit like reading a book by Spock on *Star Trek*. In fact, Dr. Grandin says that the television Spock's inability to anticipate unconsciously the emotional reactions of others is exactly the sort of problem that she and other high functioning autistics have. She gives a fascinating account of how she learned step-by-step how to develop the sort of social skills most people learn without thinking.

There is a foreword by Oliver Sacks. I was impressed by the book's medical accuracy. There are kind words for psychiatry here. Dr. Grandin has benefitted from psychiatric medication for many years now. There are fascinating accounts of how even her senses, seeing, hearing, and feeling, are different than most peoples'. She explains how this can cause some of the unusual and bizarre stereotypical behaviors of autism.

I said that the book was raw. It has not been sanitized by an editor to the point where one would think a normal person had written it. Perhaps one place where it should have been edited was the section on how Dr. Grandin can empathize with animals through thinking like them. This section becomes boring unless you happen to be a professor of veterinary medicine. Some parts of the book are quite amusing. One such part is a description of

how, with Dr. Grandin working in a "man's world," various males have tried to intimidate her, but have left feeling confused because she did not even catch on that she was being discriminated against!

Probably the most fascinating part of the book for me was a chapter where Dr. Grandin has researched various eccentric geniuses throughout history and provides a convincing case that many of them had Asberger's Syndrome (in other words, high functioning autism). She relates how Albert Einstein did not learn to speak until he was three years old, and was thought to be a dullard when he was a child. She relates: "When he worked at the Swiss patent office, he sometimes wore green slippers with flowers on them. He just did not care." About Bill Gates, she declares clothes and hygiene are low on his list of important things.

Towards the end, Thinking in Pictures gets even more bizarre. The author makes associations that normal people just do not make. The unsettling thing is that it kind of makes sense. Dr. Grandin confides, "In high school, I came to the conclusion that God was an ordering force that was in everything after Mr. Carlock explained the second law of thermodynamics.... This very literal kind of thought process is fascinating to read.

I would heartily recommend *Thinking in Pictures* if you are interested in taking a crash course in autism, if you are an intellectual, or if you are just a little different yourself.

Book Editor's Request

Dear Colleagues:

As book editor of *MASA Review*, I am seeking volunteers to write reviews for our journal. It is our intention to regularly publish book reviews by Alabama physicians of books of a medical nature, from a wide variety of pursuits with particular attention being given to books written by physicians from Alabama or with ties to the state.

I would appreciate your bringing to my attention any books you find that would be of particular interest to our readers. We hope to make this section of our journal a stimulating, distinct, and uniquely Alabama perspective.

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Medical Quiz

*Rip Pfeifer, M.D.**

Match any word on the left with the phrase on the right:

Self-serving insurance bureaucrats
Case Managers
Hospital Attorneys
Re-engineering
Case Management
Outcome-based Medicine
Authoritative Medicine
Chart Checkers
Clip-board nurses
Managed Care
Health Care Provider
Client
Practice Guidelines
Malpractice
Hold Harmless Clause
Gag Clause
Withhold
Capitation
Market Share
Economic Credentialing
Out-sourced
De-enrolled
Physician Panel
Gatekeeper
HMO
PPO
IPA
Pre-certification
Length of Stay
Specialty Subcontracting
Pooled Financial Risk
Critical Pathways
Unbundling
Outliers
Global Fee
MSO
Covered Lives
Point of Service
Copay
Referral Authorization
Re-certification

IMPROVING PATIENT CARE

*Dr. Pfeifer is a Mobile surgeon.

The Physicians Recovery Network: A Progress Report

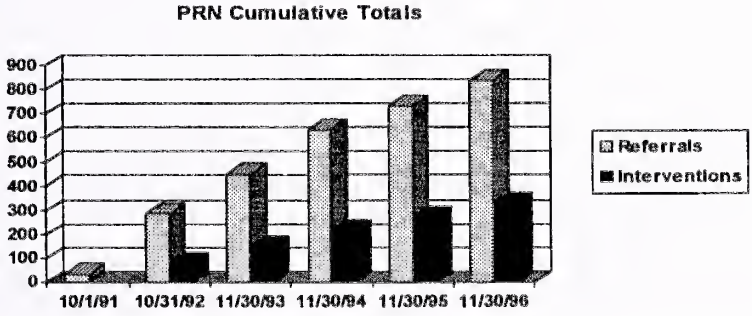
Gerald L. Summer, M.D.,
Medical Director, PRN

The Medical Association of the State of Alabama and the Alabama Board of Medical Examiners developed an impaired physicians program with a full-time medical director beginning October 1, 1991. The program is known as the Physicians Recovery Network (PRN) and is under the direction of the Alabama Impaired Physicians Committee (AIPC). PRN receives confidential referrals from a variety of sources to promote early identification of impairment as a result of chemicals, mental or emotional conditions. The goal of the program is to intervene in the disease process prior to the illness impacting upon medical care. Progressive growth of the program since 1991 indicates this goal is being realized. As shown in the graph, the total number of physicians referred to PRN has increased from 34 in October 1991 to 840 by Nov. 30, 1996.

PRN Cumulative Totals

During the past calendar year ending November 30, 1996, a total of 105 physicians was referred to PRN. All physician files are confidential. Some referrals are inappropriate for the PRN and are referred to the BME, some require no action, and others reveal insufficient information to recommend further evaluation and are placed in long term observation. After discreet inquiry respecting the confidentiality of the physician, 330 (39%) of the 840 total referrals resulted in interventions. Five (5) of those interventions involved physician assistants.

Total interventions during the past calendar year ending Nov. 30, 1996 numbered 56 (53%) of the 105 referrals. Thirty-six (64%) of the 56 interventions were referred for evaluation by a treatment provider that meets the



criteria developed by the AIPC. As reflected in the above graph, there has been a total of 330 interventions from Oct. 1, 1991 through Nov. 30, 1996. Two hundred and sixty-seven (81%) of the 330 interventions have resulted in referral for evaluation since a full time medical director became affiliated with PRN on Oct. 1, 1991. Eighty (24%) of the 330 interventions were referred to the Alabama Board of Medical Examiners.

An analysis of the first 150 interventions resulted in 70% of evaluated physicians having a diagnosis of chemical dependence, including alcohol dependence/abuse and 30% involved a diagnosis of mental illness/personality disorder.

Forty-five (45) of the PRN participants involved in the monitoring program for chemical dependency relapsed. There were twenty-nine (29) relapses during the recent calendar year. Some of these relapses were behavioral and did not include use of chemicals. Twenty-eight (28) of the physicians experiencing relapse have been reevaluated and have reentered a structured monitored program and are practicing medicine. Nine (9) currently are not practicing medicine in Alabama. One physician assistant is not currently in active practice and two physician assistants relapsed, underwent retreatment, and are currently employed in a supervised practice with a highly structured monitoring program to discourage relapse. Six (6) PRN participants have died since 1991: Two (2) with carcinoma, one (1) with active alcohol liver disease and carcinoma, one (1) suicide associated with DSM Axis I illness, one (1) with myocardial infarction, and one (1) at age 42 died suddenly, unexpectedly — possibly drug induced.

PRN is available to assist the impaired physician as long as patient safety can be assured. Currently, 146 physicians practicing in Alabama (including physician assistants) have advocacy contracts with PRN. The number of advocacy contracts varies due to death and relocation out of state. PRN continues to advocate for recovering physicians to the BME, other state regulatory agencies, insurance carriers, hospital credentialing committees, physician groups, and managed care entities.

PRN promotes the goals of identifying the impaired physician prior to any illness impacting on medical care.

PRN is available to the Alabama Board of Medical Examiners to receive referrals from the Board for evaluation of any physician who has been addicted to the use of alcohol or controlled substances and/or who has received any treatment, monitoring, or aftercare for chemical dependency, substance abuse, or psychiatric illness within ten years preceding the application for a license to practice medicine in Alabama. For the majority of these referrals a recommendation for an independent assessment has been of assistance to the Board and the physician in evaluating the physician's licensing application. PRN has assisted the Board in the assessment of 85 licensing applications since 1993. During the recent calendar year, PRN has assisted the Board in 22 applications.

PRN promotes the goals of identifying the impaired physician prior to

any illness impacting on medical care. PRN makes available the following educational programs to assist in achieving these goals:

1. Recognizing Signs and Symptoms of Substance Abuse in the Physician
2. Guidelines for the Development of Hospital Wellness Programs
3. Preventing Allegations of Professional Sexual Misconduct
4. Managing the Behaviorally Disruptive Physician
5. Early Identification of the Impaired Physician and its Positive Impact on the Medical Marriage
6. Recognition of Patient Drug-Seeking Behavior
7. Advocacy and Urine Drug Screening in Physicians
8. Recognizing Stress in the Physician
9. Helping Physicians Identify Alcoholic Patients in Their Practice

During the past calendar year, 32 programs have been given in Alabama to hospitals, physician groups, the ABME, and the Medical Alliance.

In 1993, the medical director of PRN served as an active consultant to the ad hoc committee appointed by the Federation of State Medical Boards (FSMB). In 1996, this committee completed uniform guidelines for all state medical boards to develop impaired physician programs that assure patient safety and physician advocacy as well as guidelines for state medical boards to consider in developing policy and procedures to manage referrals of allegations of sexual misconduct in the physician-patient relationship. During the recent calendar year, the medical director of PRN participated as a faculty member in four (4) FSMB regional workshops in the United States that presented these guidelines.

The medical director of PRN currently serves as President of the Federation of State Physician Health Programs (FSPHP). The FSPHP is a national organization whose purpose is to provide a forum for information exchange between state impaired physician programs and to develop standards to assist new state programs. The FSPHP participated as a cosponsor of the 1996 AMA International Conference on Physician Health. During the meeting, the medical director of PRN chaired a symposium on Current National Efforts to Assist Impaired Physicians with a representative from the FSMB, the director of the Mental Health Division of the AMA, and the medical director of Physician Health Services of the Massachusetts Medical Society. These endorsements promote MASA's PRN as a leading program in the United States.

...over 90% of physicians involved with chemicals or having mental/emotional illnesses can return to the productive practice of medicine...

The PRN experience is that over 90% of physicians involved with chemicals or having mental/emotional illnesses can return to the productive practice of medicine with assurance of patient safety. This encouraging prognosis is similar to other full time state programs with similar stable and adequate funding. MASA's efforts to encourage this valuable resource for Alabama physicians and their patients are to be commended.

Members of the Alabama Impaired Physicians Committee

(pictured at left)

Sam C. West, Jr., M.D., Chairman
Dothan - (334)793-1964

William H. Goodson, Jr., M.D.
Huntsville - (205)881-3231

C. Neal Canup, M.D. Vice-Chairman
Anniston - (205)237-8527

Pete Cox, M.D.
Florence - (205)757-4915

Charles W. Daniels, M.D.
Mobile - (334)433-6536

Harrison M. Goodall, M.D.
Tuscaloosa-(205)554-2000, Ext. 2441

Philip R. Hanlon, M.D.
Mobile - (334)432-4415

William Jerry Howell, M.D.
Birmingham - (205)664-3460

William M. Reid, M.D.
Muscle Shoals - (205)381-4730

Larry Rigsby, M.D.
Montgomery - (334)270-8081

Howard M. Sanford, Jr., M.D.
Madison- 1-800-879-7272

Carl B. Shory, M.D.
Birmingham- (205)595-4247

Jon E. Sanford, M.D.
Fayette - (205)932-3900

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10 Caveats on Managed Care Contracting

*Neil Baum, M.D.**
David Sorrells†

Abstract:

Capitation will become a term that nearly every physician in the state of Alabama will become familiar with in the very near future. However, few physicians are skilled at evaluating a capitation contract. This article will review the necessary steps that should be considered before signing a capitation contract.

Today only 5% of Americans are covered on a capitation basis of reimbursement to the physician providers. By the year 2005 it is estimated that nearly 50% of the population will be covered under a capitation contract. Unfortunately, there are very few physicians capable of evaluating a capitated managed care contract. Unfortunately, few medical schools cover managed care contracting in their curriculum. There are many seasoned physicians who have signed contracts without reading the contract and as a result there are more than a few physicians who have experienced severe financial consequences because of not being able to cover the overhead costs of caring for the patients under the capitated system of reimbursement. Evaluating the capitation contract is the first and probably most important step in managing the risk of capitation. This article will review the 10 caveats that must be evaluated in any capitated contract. Although this is not a complete list, it does cover the most important areas of capitated managed care contracting.

It is important to always keep in mind that the underlying purpose of capitation is to transfer some of the risk from the payor or managed care organization to the provider or the physician. From the perspective of the physician, the success or failure of entering into a capitated method of reimbursement requires the physician to accept only the risk that can be adequately and safely controlled. Ultimately this requires accepting a contract that is fair, manageable, and profitable.

If you have seen one contract...you've seen one contract. Not all contracts are the same. However, if you follow a few caveats and prepare a check list that covers the basics elements of a contract, you will enter the negotiations with confidence and security. To wing it or accept a contract on faith and trust is going to result in accepting more risk than you can manage and will have repercussions that will negatively impact your practice.

1. Menu of Services

Probably the most important area to assess in any capitation contract is

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the menu of services which you will be responsible for providing for the patient population upon which the contract is based. The menu of services can be determined by requesting a list of every service, identified by CPT code, that is to be included in the contract. Most contracts will contain specific exclusions which are not covered under the capitation contract. Exclusions should include medications, immunizations, and costs for durable medical supplies. The best advice is that if a particular service is not excluded in the contract, you must consider it to be included.

In some instances, you or your practice may not have the expertise or the desire to provide care for the full range of medical services. For example, you may want to carve out expensive treatments such as organ transplantation and bone marrow transplants. In these instances, a carve-out can be added to the contract. Carve-outs represent those services which your practice is not expected to provide. Separate contracts can be negotiated with specialists to provide for these services. It is imperative that the contract specify who will be financially responsible for these carved-out services. If you accept that financial responsibility then your capitation rate must reflect that added risk. It is our recommendation that in the beginning, when you are developing your comfort level with capitation, that you shift the risk and financial responsibility to the managed care organization for the carve-outs and those areas that are beyond your control. Examples include out of area medical care and treatment of medical emergencies.

You should also consider whether supplies and durable medical goods are covered in the contract.

It is imperative that you give careful attention to deciding whether labs, medications, and x-rays are the responsibility of the practice. If your practice is able to perform some x-rays and lab work it may be beneficial to accept capitation for these services. You should also consider whether supplies and durable medical goods are covered in the contract.

2. Utilization of Services

Next, it is vital to determine the expected utilization for each of the CPT codes in the menu of services. This is the most ideal method to determine the capitation rate or the per member per month fee that you will receive for the population that you will cover. Unfortunately this data is not always accessible and if it is, you are not always certain that the information that they provide is accurate. Most reputable MCOs will share their utilization data with you and you should request the previous two-year claims history. Also the AMA Center for Health Policy Research has developed national utilization rates stratified by age, sex and specialty based on private sector fee-for-service. In order to obtain accurate utilization data it is critically important to know the demographic variables of the population that you will cover. This includes age, sex, and occupation of the covered population. For example, women have more urinary tract infections than men and will require more services for this medical problem. An older population

requires more medical services than a population between the ages of 25-50 years. A blue collar population will have more work-related injuries and require more services than those employed in offices. This is why it is important to know the demographics of your population before you accept any contract.

With accurate utilization data you can determine a ball park capitation figure. However there are other variables that make it difficult to derive an accurate figure that will result in a profit for your practice. These other variables include: local standards of care which may impact specific utilization, the general competence of the primary care physicians in the community, and the incentives driving potential referring physicians. It is important for the contract to contain provisions to prevent dumping of minor or trivial problems or conditions that can be treated by the primary care physician. A safe-guard to prevent dumping would be a limit on the number of patients seen and when that limit is exceeded any additional referrals are paid on a fee-for-service basis.

...physicians need a minimum number of members for capitation; otherwise the practice runs a substantially higher financial risk.

It is important when beginning a capitation contract that physicians need a minimum number of members for capitation; otherwise the practice runs a substantially higher financial risk. This minimum number of members will vary with the speciality and with the age group. For example, in a urology capitated contract, the generally accepted minimum is 10,000 for commercial population and 1000 for Medicare. However, a primary care physician might be able to successfully capitate as few as 500 patients and still be profitable. Remember, the more patients enrolled, the more the risk is spread out and it becomes less likely that a few expensive cases can negatively impact the bottom line.

It is important to also consider under the topic of utilization of services how patients will have access to the physicians, especially to specialists. A popular concept is the point of service or open access type of arrangement where patients can have the option of obtaining health care outside of the plan for a higher co-payment. If patients have this option, this will usually reduce the per member per month capitation rate.

3. Stop-Loss Insurance

It is necessary that you consider the potential impact that one or two catastrophically ill patients may have on your practice. If you are new at capitation contracting or you are responsible for a small patient population then you will want to consider including a stop-loss provision to address excessive costs that can occur from managing the patient that has a costly complication such as a urinary fistula following a urinary diversion. We suggest that your contract include protection against the cost of providing care that exceeds a threshold amount, either on a per-member or group basis. You should request that this insurance be provided by the MCO that is offering the contract. Ideally, a good contract should provide a risk corridor, which is

a range of utilization levels above and below what is predicted, and a provision for adjusting the capitation rate when utilization falls outside of the corridor.'

If the HMO is paying for the stop-loss insurance, you can request how much this insurance costs and how much they are reducing the cap rate. You may decide to pay this insurance yourself if you can increase the cap rate. If you have a sufficient number of members in the plan, and the risk is sufficiently spread out among a large number of members, you may try to skip having a stop-loss provision. If you do decide to skip the stop-loss insurance, the contract should cover only physician services, i.e., no durable medical goods, medications, or other supplies. This way the physician is at risk for only the loss of their time. Deleting the stop loss insurance would not be advised in the early stages of capitation contracting.

4. Copayments

The presence or absence of patient copayments significantly effects utilization. Numerous studies have demonstrated that copayments as low as $5 or $10 will significantly decrease utilization. Another advantage of copayments is that the small fee serves as an immediate revenue at the time the service is rendered. This only works if the copayment is collected at time of service since billing for small amounts is not cost-effective.

5. Physician Withholds

A withhold or risk pool arrangement is a promise of potential financial reward offered to cost-effective physicians usually at the end of the year. A withhold clause gives the MCO the right to retain a portion of payments to protect against over-utilization of resources. When the utilization and resulting cost of providing care is less than projected, there is a surplus in the withhold fund, and this amount is then distributed to the providers. If over-utilization occurs, the withhold pool is used to pay for the excess costs resulting in a decrease in reimbursement to the providers. Specialists need to know what other participants are in line to receive the withhold or bonus. In most contracts the amount of the withhold payout will be determined by decisions made by all of the physicians who participate in the pool and not on the basis of the specialists' cost-effectiveness alone. It is very useful to review an example or illustration of how the withholds are calculated and incorporate the example into the contract. We also suggest that the contract includes an agreement for reviewing adequate reports from the MCO and also for access to the MCOs financial records for purpose of verification. The contract should also state the withhold pool be kept in an interest-bearing account and that the interest be at least shared or given totally to the providers.

Deleting the stop-loss insurance would not be advised in the early stages of capitation contracting.

In markets that have more experience with capitation, there are no withholds. The groups that accept the contract are responsible for over-utilization. Progressive HMOs are not using

withholds but an incentive arrangement that is tied to the reduction of utilization of services, of course, within the HCFA Guidelines as a method of incensing the providers. In fact this latter method of using incentives could provide substantially more money to the providers than the capitation rate plus the withhold system especially since most HMOs will not disclose their formulas for calculating the utilization requirements that must be met to receive a payment of the withhold.

6. Most Favored Nation Clause

Many MCOs include a most favored nation (MFN) clause in the contract. This provision states that if a practice contracts with other MCOs for a greater discount in the fees charged in the contract, that discount must also be extended to this plan. MFN lets the first MCO remain competitive with other MCOs in the community . Make every effort to delete this clause from your contract. If the MCO demands that the MFN be left in the contract then you should demand the right of first refusal for any other capitation contract which the plan may have in the future. This would mean that if they make a contract with another group, you have a right to take those patients at that price before they can contract with another group.

7. Hold Harmless Clause

Some HMO contracts also have a hold harmless clause which transfers all medical liability risk to the physician if the plan is sued. This should be vigorously negotiated out of the contract but if the payor insists and if the contract appears worthwhile, physicians must ensure that they have adequate malpractice coverage and, if necessary, buy more coverage. In some states, such as Alabama, the dominant malpractice carrier will not provide any coverage for this type of clause. If the malpractice insurance does not provide coverage when a hold-harmless clause is included, then payment will come from the physicians personal funds.

8. Termination Clauses

Termination and renewing the contract are also important aspects of any managed care contract. In general the termination clause should be equally binding so that criteria for termination and amount of notice required should be equal for both parties. The most common language of the contract includes termination with or without cause upon 90 days written notice. We suggest that you ask for a 6-12 month termination clause. That way both parties, the physicians and the HMOs have a commitment to an extended relationship.

Termination and renewing the contract are also important aspects of any managed care contract.

Many contracts contain an automatic renewal clause unless either party wishes to renegotiate the contract. There should be language in the contract that if you terminate the contract and the MCO wants you to continue caring for the patients that you will be compensated on a fee-for-service basis.

The term or the duration of the contract is also an important issue. If

the cap rate appears to be favorable and if the practice decides there is significant room for lowering utilization, a two- to three-year contract may be desirable. In the beginning when you are making the transition from fee-for-service to a capitated method of reimbursement, we recommend starting with a one-year term as this carries less risk than being locked into a longer contract that is not profitable. If this is your first capitated managed care contract or if you have no experience with the managed care organization or the patient population, we recommend structuring the contract that allows for a trial period during which the financial risk is limited or can be modified if there is increased utilization.

...a one year term...carries less risk than being locked into a longer contract that is not profitable.

9. MCOs Stability and Financial Condition

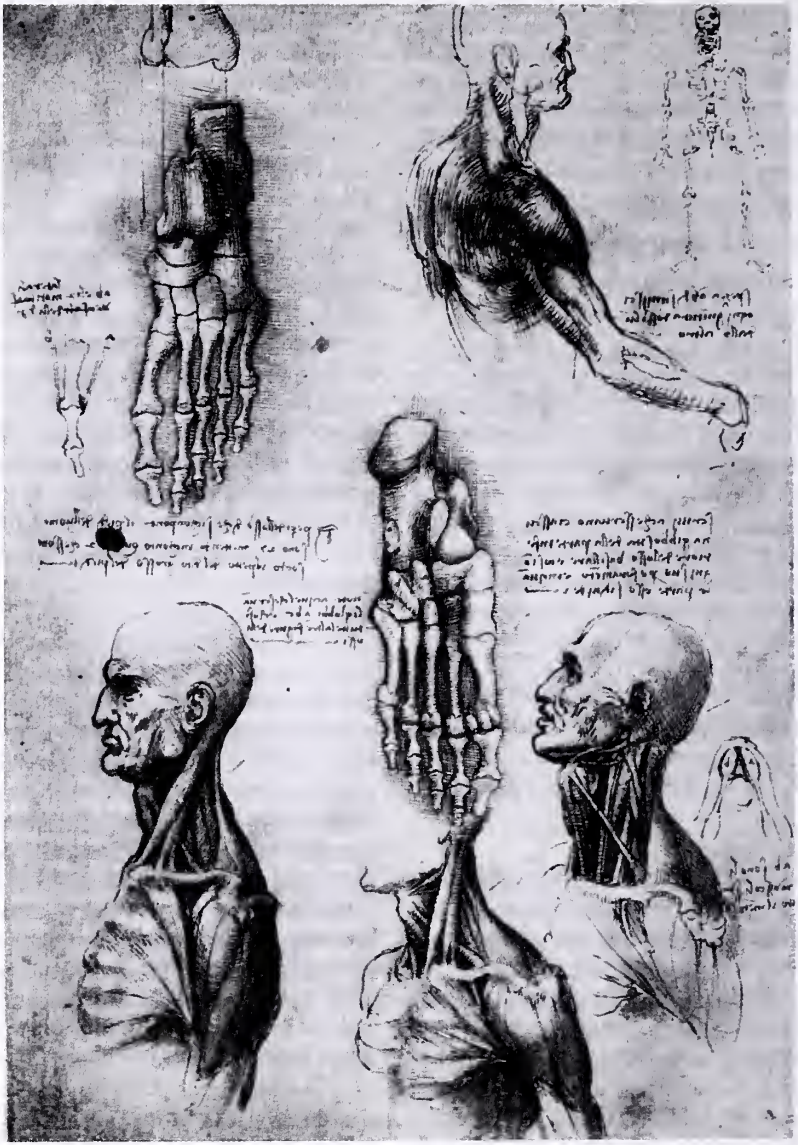
It is not uncommon for a MCO to enter a community and begin capitating the population only to go bankrupt in just a few years. Consequently it is important to know the financial condition of the plan. This would include reassurance in the contract that the plan has adequate financial reserves and reinsurance to cover catastrophic losses or insolvency insurance that will pay physicians for their services in the event that the MCO declares bankruptcy.

10. Payments and Penalties

The contract should clearly specify when payment will be made and include penalties for delays in payments. Most MCOs will object to a penalty clause but it is important to include it in order that they are financially motivated to make payments in a timely fashion. It is also important to include in the contract when members are enrolled and disenrolled so you can accurately calculate how many members are added or subtracted from member list.

Summary

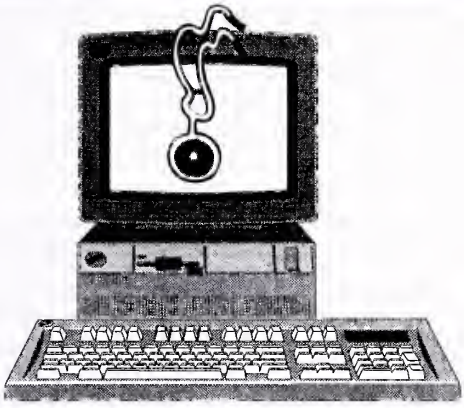
It is not easy to shift gears from fee-for-service to a capitated method of reimbursement. A good piece of advice is to get good advice, i.e., legal counsel from an attorney or law firm with known expertise in managed care contracting. Finally the best advice is to be proactive and make the transition early. Certainly mistakes will be made in the beginning with capitated contracts. But the mistakes are less costly when capitation consists of only a small portion of your practice rather than the 50% that is expected in the not too distant future.



An anatomical study by Leonaro da Vinci, one of 750 surviving drawings.

Weaving the Web: A Physician's First Spin

*Tamera P. Lee, M.L.S.**



As medical information continues to increase at an exponential level, the Internet is an important resource in enhancing access to this information. The Internet explosion includes a vast amount of medical resources and provides connectivity through an international exchange for information such as new developments, treatments, standards, consumer health communication and learning, continuing education and employment opportunities. The World Wide Web (WWW) serves as an interactive, multi-media browser to enable the searcher to tap the world's resources conveniently and rapidly. The purpose of this selected bibliography is to provide some of the most organized and developed WWW sites for physicians.

**President, Alabama Health Libraries Association
Head, Cary Veterinary Medical Library, Auburn University**

These sites particularly are useful for the physician who is just beginning to explore the Internet, as they are general, thorough and interactive, with a multitude of hypertext links to other medical specialities. For each selected site, the following information will be provided: title of resource; alternative title; URL (Universal Resource Locator), i.e., Internet address; additional access information; host site where the resource is located; information provider; contact person information; keywords describing the content; table of contents; description and abstract of the resource; any additional information; and date of review.

This brief bibliography is intended for those Alabama physicians ready to begin browsing the Internet, as well as those who want to explore further the power of information the Internet offers.

TITLE: The Virtual Medical Center

URL:http://www-sci.lib.uci.edu/~martindale/Medical.html

HOST: University of California, Irvin (UCI) Science Library, Jim Martindale, and Frank Potter

PROVIDER: UCI Science Library, U.S. Department of Defense, National Institutes of Health,

National Science Foundation

CONTACT: jmartindale@VMSA.oac.uci.edu

SUBJECT: Virtual Medicine; Medical Informatics

CONTENTS: World Daily Reports; What's Happening Today?; Primary Technical Support; Travel Warnings and Immunization; Law Center; Reference Desk; International Services; Virtual Hospitals and Medical Schools; Medical Dictionaries and Glossaries; Medical Courses, Textbooks, Modules and Cases

DESCRIPTION: This searchable WWW site contains over 17,800 multimedia medical teaching files and modules, over 26,500 interactive, multimedia medical cases, 193 multimedia medical school courses and texts and over 3500 MPEGs (movies). All information is arranged alphabetically by medical specialty. Additionally, the Virtual Medical Center contains postal and world maps, dictionaries, journals newspapers, electronic calculators, grant information, world daily reports, travel warnings, and a legal and medical reference center.

ADDITIONAL INFORMATION: Top 5% of all Web sites; Magellan 4 star site

DATE ENTERED: 02/05/96

TITLE: Medical Matrix Guide to Internet Clinical Medicine Resources

URL: http://www.kumc.edu:80/mmatrix/index.html

ADDITIONAL ACCESS INFORMATION:

Gopher://una.hh.lib.umich.edu:70/00/inetdirsstacks/medclin:malet

HOST: University of Kansas Medical School Dykes Library

PROVIDER: Internet Working Group of the American Medical Informatics Association

CONTACT: Dr. Gary Malet (gmalet@healthtel.com); Lee Hancock (LE07144UKANVM.bitnet@VM42.CSO.UIUC.edu; and Jim Martindale (king Lincoln. siumed. ecu)

SUBJECT: Medical Informatics; Clinical Practice

CONTENTS: News; 1995 Survey of Internet Clinical Medicine Applications; Disease and Specialty Categorized Information; Clinical Practice Issues; Medical Education; Medical Literature Searches; Basic Medical Sciences; Medical Virtual Communities; Medical Software Data banks; Multimedia Modules; Medical Images; Discussion Forums; Continuing Medical Education; Teaching Files; Textbooks; Multimedia Cases and Educational Modules; Electronic Journals and Newsletters; Employment Resources; Health care Industry; Practice Management Resources; Patient Education and Support; Introduction to Medical Internet Resources; Medical Internet Resource Guides

DESCRIPTION: The Medical Matrix is a hypertext, hyper linked database

designed for use as an Internet homepage for physicians, offering comprehensive access to "global resources that can assist in patient care." Whereas the resources emphasized are relevant to clinical practitioners, they are of interest also to the general public for consumer health purposes. The searchable, peer reviewed directory of Internet health resources especially is unique. The Medical Matrix provides efficient access to other searchable databases, such as Physicians GENRX,the U.S. Government Center for Disease Control. The Matrix also includes a qualitative image file, with textual annotations, for pathology, radiology and dermatology. Disease information, teaching files and CME courses are categorized by medical specialty. The Medical Meeting Place provides CME course listings and registration. In addition, the Matrix provides access to numerous electronic journals and newsletters, as well as excellent guides to the Internet's medical resources. Efficiently accessible, this is a highly useful site, authoritative and rich in content.

DATE ENTERED: 02/05/96

TITLE: Doctor's Guide to the Internet
URL:http://www.pslgroup.com/docguide.htm
HOST: P\S\L Consulting Group, Inc.
PROVIDER: P\S\L Consulting Group, Inc.
CONTACT: Webmaster@pslgroup.com
SUBJECT: Medicine, Health care, Drugs

CONTENTS: News, New Internet Sites, Recently Approved Drugs, Conferences, Exchange, Internet Medical Resources, Financial and Business Management, Travel and Leisure, Consumer Health Information

DESCRIPTION: This well-organized and searchable site provides timely and useful information for physicians and allied health professionals, and, consumers as well. The professional edition of The Doctor's Guide includes numerous hot links to resources of medical and professional interest, such as the latest conference news, literature and Internet sites. CME events are indexed by country/city, month and subject area. The Doctor's Guide also includes information of personal interest, such as financial and business resources, as well as travel and leisure. The patient edition of this Web site includes a multitude of consumer health links of interest to patients, resources on topics such as aids, breast cancer, cholesterol, depression, diabetes, migraine and sports injuries.

ADDITIONAL INFORMATION: Awarded 4 stars by McKinley's Internet Directory

DATE ENTERED: 02/05/96

TITLE: American Medical Association
ATITLE: AMA
URL: http://www.ama-assn.org/
HOST: AMA
PROVIDER: AMA
CONTACT: WebAdmin@ama-assn.org

SUBJECT: Medical Organizations, Electronic Journals

CONTENTS: About the AMA; What's New?; Medical Science and Education; Membership and Services; Advocacy and Communications; AMA Catalogs; AMA Publications; Medical Hot Links

DESCRIPTION: As the home page of the American Medical Association, this site provides information about the national organization, including membership and services. It provides a directory of state, local and specialty societies, as well as grassroots political action and current trends in the medical sciences and education. Plans are underway to provide a link to continuing medical education. Also, AMA provides information on products for physicians, medical students and consumers. Upon registration as an AMA member, searchable access is given to the Web editions of JAMA, including tables of contents, abstracts of major manuscripts and recruitment. Additionally, access is provided to electronic versions of a wide variety of other AMA journals.

DATE ENTERED: 02/06/96

TITLE: National Library of Medicine

ATITLE: HyperDOC, NLM

URL: http://www.nlm.nih.gov/

HOST: National Library of Medicine

PROVIDER: U.S. National Library of Medicine, National Institutes of Health, Department of Health and Human Services

CONTACT: Rodgers@nlm.nih.gov or suresh@thomtech.com

SUBJECT: National Library, Medical Libraries

CONTENTS: About NLM; News, NLM Publications; Collection Profile, Current Events, Personnel, Online Information Services, Research and Development (Intramural and Extramural); The Visible Human Project

DESCRIPTION: As the home page for the National Library of Medicine of the United States, this multimedia hypertext resource provides electronic access to the "world's largest library dealing with a single topic." The Visible Human Project (VHP), NLM's project to create a digital atlas of human anatomy, currently provides anatomical data; however, the long-term goal is "to produce a system of knowledge structures that will transparently link visual knowledge forms to symbolic knowledge formats such as the names of body parts." Eventually VHP will provide "complete, anatomically detailed, three-dimensional representations of the male and female human body."

ADDITIONAL INFORMATION: "Credit for contributions to specific documents or services available via HyperDOC appears in conjunction with the contributed materials."

TITLE: Medscape

URL: http://www.medscape.com/

HOST: Medscape, Inc.

PROVIDER: Medscape, Inc.

CONTACT: Stephen-Smith@medscape.com (clinical editor)

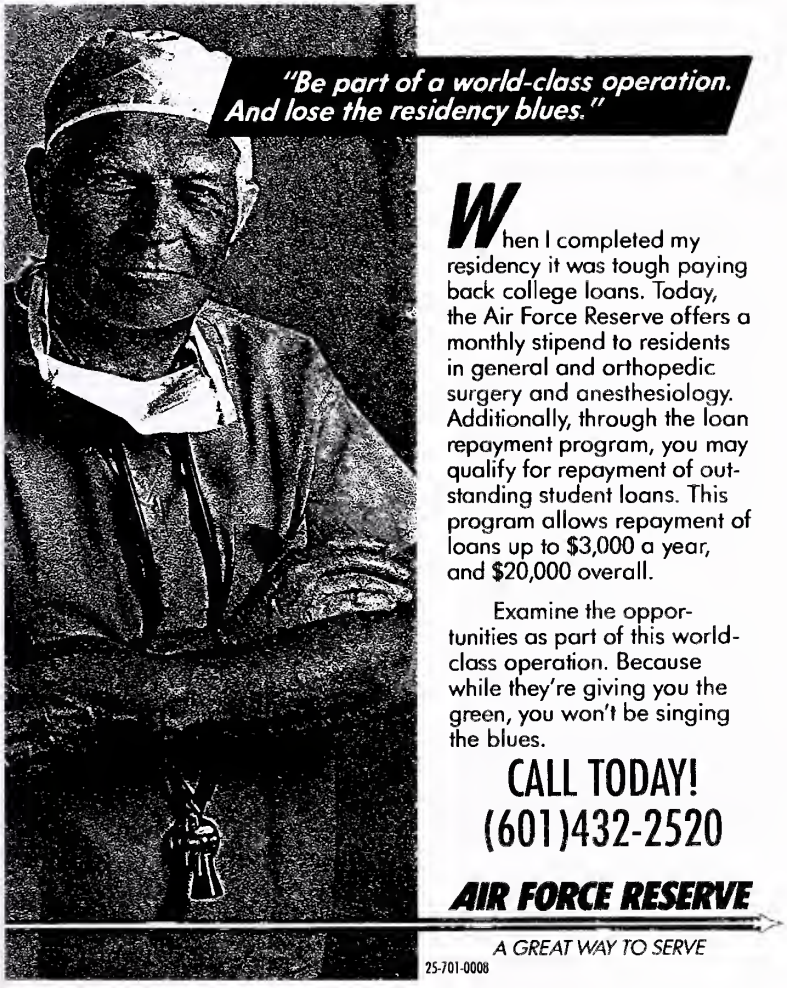
SUBJECT: Patient Care; Consumer Health; Databases

CONTENTS: Patient Information; CME Center; Search; News; Journals; Exam Room

DESCRIPTION: With a one-time, no cost registration, Internet clients may search bibliographic abstracts of NLM's MEDLINE database, AIDSLINE database (a subset of MEDLINE for aids research), as well as the full-texts of journal articles from over 100 core medical journals, including graphics. As a peer-reviewed site, Medscape is targeted at physicans and other health care professionals to help keep them informed of the latest news headlines and research of the health care industry, and, CME offerings. Consumers may browse the latest health topics of interest. The "exam room" features an interactive, self-assessment guide.

ADDITIONAL INFORMATION: *USA Today* Hot Site; Top 5% of all Web Sites; Magellan 4-Star Site; Physician's Choice

DATE ENTERED: 09/01/96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The Lost Art of Handwashing

*Ernest S. Campbell, M.D., FACS**
divedoctor@earthlink.net

In my hospital there was a prominent surgeon who had a fetish for hand washing, over and above the usual scrubbing that surgeons do in preparation for their operations. This phobia or neurosis was carried to great lengths by this very intelligent man, and I always wanted to sit down and discuss it with him—but somehow never got up the courage to broach the subject with him.

Whether his need to wash his hands was driven by supreme guilt over some blown-out-of-proportion childhood incident, or by a dire fear of contracting a contagious disease—I never knew. I do know that it extended to the avoidance of shaking hands, using towels to touch door knobs and faucets and of having to repeat the washing process if any of his "rules" were violated. Oddly enough, his wound infection rates were significantly higher than the usual in our hospital, and I often wondered whether there was any relationship to his excessive hand washing routine.

This brings me to my point—recent reports indicate that hand washing can almost eliminate one of mankind's scourges—the common cold! It also seems that there are numerous viral and bacterial infections that are mainly transmitted by touching hands or inanimate objects touched by hands from people who have active infections, and, that adherence to a hand washing routine can go a long way to blocking the transmission of infectious diseases. The surgeon in my hospital had the right idea but went about it in the wrong way.

How many of us shake hands or are touched by someone else in the course of going about our business and doing the things we have to do? How often do we eat food prepared by individuals with nasal, bronchial or hand infections? What protection can we expect from food handlers, hairdressers, pharmacists and other health professionals? Yes—there are laws that state how things should be done—but are these laws being carried out?

150th Anniversary of Simmelweis

1997 marks the 150th year since the discovery of the importance of hand washing in infection control. During the 19th century, women in childbirth were dying at alarming rates in Europe and the United States. Up to 25% of women who delivered their babies in hospitals died from childbed fever (puerperal sepsis), later found to be caused by Streptococcus pyogenes bacteria.

As early as 1843, Dr. Oliver Wendell Holmes had advocated hand washing to prevent childbed fever. Holmes was horrified by the prevalence in American hospitals of the fever, which he believed to be an infectious disease passed to pregnant women by the hands of doctors. He recommended that a physician finding two cases of the disease in his practice within a short time should remove

**Ono Island, AL.*

himself from obstetrical duty for a month. Holmes's ideas were greeted with disdain by many physicians of his time.

In the late 1840s, Dr. Ignaz Semmelweis was an assistant in the maternity wards of a Vienna hospital. There he observed that the mortality rate in a delivery room staffed by medical students was up to three times higher than in a second delivery room staffed by midwives. In fact, women were terrified of the room staffed by the medical students.

Semmelweis observed that the students were coming straight from their lessons in the autopsy room to the delivery room. He postulated that the students might be carrying the infection from their dissections to birthing mothers. He ordered doctors and medical students to wash their hands with a chlorinated solution before examining women in labor. The mortality rate in his maternity wards eventually dropped to less than one percent.

"The thing that kills women with [childbirth fever]...is you doctors that carry deadly microbes from sick women to healthy ones."

Despite the remarkable results, Semmelweis's colleagues greeted his findings with hostility. He eventually resigned his position. Later, he had similar dramatic results with hand washing in another maternity clinic, but to no avail. His observation was derided by the medical profession and he ended up in an insane asylum 10 years later and died.

Louis Pasteur

In the 1870s in France, one hospital was called the House of Crime because of the alarming number of new mothers dying of childbed fever within its confines. In 1879, at a seminar at the Academy of Medicine in Paris, a noted speaker stood at the podium and cast doubt on the spread of disease through the hands. An outraged member of the audience felt compelled to protest. He shouted at the speaker: "The thing that kills women with [childbirth fever]...is you doctors that carry deadly microbes from sick women to healthy ones." That man was Louis Pasteur. Pasteur, of course, contributed to the germ theory of disease (whereas the founder to this theory was Robert Koch). He was a tireless advocate of hygiene, but his efforts too were initially met with skepticism.

Skepticism, however, was not the only problem facing advocates of hygiene. In 1910, Josephine Baker, M.D., started a program to teach hygiene to child care providers in New York. Ironically, a large group of physicians sent a petition to the Mayor protesting that "it was ruining medical practice by...keeping babies well."

AMA Resolution

Several years ago the AMA sponsored a resolution to remind AMA doctors that they have a professional obligation to wash their hands. Proposed by Duncan Clark, Professor Emeritus of Preventive Medicine at S.U.N.Y. Health Science Center in Brooklyn, it called for an AMA campaign lasting until 1997 for improvements in hand-washing practices. "The valuable lesson of hand-washing before and between examining each

patient is today honored mostly in the breach," said Dr. Clark, an AMA member. Studies indicated that doctors wash their hands only 14 percent of the time before seeing patients.

CDC

According to the United States Centers of Disease Control and Prevention (CDC), "Hand washing is the single most important means of preventing the spread of infection." Yet, recent studies and reports indicate that lack of or improper hand washing still contributes significantly to disease transmission. While we are all potentially at risk of contracting hand-transmitted illnesses, one-third of our population is especially vulnerable, including pregnant women, children, old people, and those with weakened immune systems.

Hospitals

It would seem reasonable to assume that hospitals have come closest to responding to this problem. Modern surgery has long since solved many of the early problems of infection but fundamental problems of hygiene still exist. In 1992, *The New England Journal of Medicine* reported on a hand washing study in an intensive-care unit. Despite special education and monitored observation, hand washing rates were as low as 30% and never went above 48%!

In health care, nurses and doctors wash only 30% of the required time between patient contacts and procedures. Each year over two million nosocomial infections occur in the US alone. They cause an estimated 30,000 deaths and contribute to another 70,000 deaths each year. Nosocomial infections cost over $2300 per incident and $4.5 billion annually in extended care and treatment (Source: CDC).

Through patient contact health care workers are a leading cause of transmission of nosocomial infection.

In health care, nurses and doctors wash only 30% of the required time between patient contacts and procedures.

In the case of Hepatitis B. health care workers are between 5 and 15 times more likely to contract the virus than the general US population (Association of Infection Control Professionals). According to *JAMA*, The Journal of the American Medical Association, the cost of a program to control the spread of nosocomial infections is outweighed by the money saved by preventing nosocomial infections. (Source: *JAMA*, The Journal of the American Medical Association, p3048(2) Dec 2 1992 v268 n21).

Food borne Illness

Food-borne illness kills over 10,000 people each year. Over 70% of all outbreaks originate in food service operations and, as many as 40% are the result of poor hand washing and cross-contamination. Each year over 80 million estimated cases of food poisoning occur in the United States alone. The US spends between $7.6 and $23 billion annually on health care and lost productivity resulting from food borne illness. The average incident costs the food service company over $75,000 and results in significant future sales losses. (Source: FDA)

Nursing Homes, Long-Term Care

Nosocomial infection is the most common immediate cause of death in nursing home patients, and the leading cause of patient hospitalization. The CDC estimates over 1.5 million cases of nosocomial infection in long-term care facilities and nursing homes occur each year, or an average of one infection per year per patient. According to the American Journal of Infection Control (June/August 1991), between 5% and 18% of all patients have an active infection at any given time.

Daycare

"In spite of all the studies about the benefits of hand washing, improper or infrequent hand washing continues to be a major factor in the spread of disease in day-care," that according to a recent study published in the medical journal, *Infectious Diseases in Children*. Researchers recovered fecal coliforms from the hands of one out of every five staff members, citing that more than 33% of daycare facilities "had poor hand washing techniques and no policy for hand washing before eating or after playing outside. In spite of all the studies about the benefits of hand washing, improper or infrequent hand washing continues to be a major factor in the spread of disease in day-care". (Source: Infectious Diseases in Children, Volume 4, July 1991).

Conclusion

In 1996, the lack of hand washing is surprising. We have hot running water and the benefits of many antimicrobial soaps to prevent infections. In the food-service industry, studies indicate that inadequate hand washing and cross-contamination is responsible for as much as 40% of foodborne illnesses, including Salmonella. It is estimated that there are over 80 million cases of food poisoning in the United States each year, resulting in greatly increased health care costs, loss of job productivity, and as many as 10,000 deaths per year. About 30,000 people die from nosocomial infections each year, due primarily to the lack of infection control programs. $500 million would be saved if just 17% of the nosocomial infections were prevented. This money could be used for such things as cancer or AIDS research. What a simple act, hand washing, with such remarkable benefits if it were to be practiced properly. Improper hand washing is a critical factor in the spread of bacteria, pathogens, viruses causing disease, foodborne illness and hospital induced infections.

About 20,000 people die from nosocomial infections each year, due primarily to the lack of infection control programs.

Hand washing Agents

There are six antimicrobial ingredients commercially available in the United States that are indicated for routine hand washing, high risk hand washing, and surgical scrubs.

- Alcohol: 60% to 90% volume
- Chlorhexidine gluconate (CHG): 2% and 4%
- Hexachlorophene: (prescription only)
- Iodophores: (PVP or povidone).

The most common concentration is 7.5%

- PCMX (chloro-meta-xylenol) (chloroxylenol) 0.5% to 3.75%
- Triclosan (Irgasan) 0.3% to 2%

Hand washing Techniques
5 basic steps to hand washing

1.Wet hands with water then add soap.
2.Use friction to generate lather and wash hands for at least 10 seconds.
3.Rinse well under a stream of water
4.Dry hands thoroughly
5.Turn off faucet with paper towel

When to Wash Your Hands:

- Beginning and end of the work day.
- Before and after each patient con tact
- Before and after using gloves.
- Before eating, smoking, or handling medications.
- After using the toilet
- After wiping the nose or touching the face.
- After touching contaminated sur faces.

Hand-shaking and Neckties

The age-old practice of shaking hands as a greeting (or to indicate the lack of a weapon) may be coming to an end. I'm thinking that the greeting of Star Trek's Mr. Speck and that of the American Indian probably would function better toward the prevention of infection—the upraised palm serving as a safe greeting and at the same time showing the lack of a weapon. I'm not quite sure how to work in the muttered "Peace" or "How!" into this discussion, but I'm sure society will manufacture one. Now, if we could only find a real good reason to get rid of men's neckties!!

1997 Medicare RBRVS and Conversion Factor Final Rules

American Medical Association

On November 22, 1996, the Health Care Financing Administration (HCFA) published in the Federal Register the Final Rules on the 1997 Medicare RBRVS and conversion factor updates. The most significant aspect of the RBRVS Rule is that it represents the completion of Medicare's first, comprehensive five-year review of the RBRVS. It is clear that the five-year review very successfully addressed many long-standing concerns about the accuracy of the relative values for many services, including evaluation and management, gynecology, anesthesiology, psychiatry, and many surgical and other procedures. Throughout this process, HCFA relied heavily on the analysis and recommendations of the AMA/Specialty Society RVS Update Committee (RUC) for increasing and decreasing relative values where changes were warranted, and for maintaining the current relative values where proposed changes were not justified. Finally, to maintain "budget neutrality," HCFA agreed for the first time to establish a separate budget neutrality adjustment factor for the changes generated by the five-year review, an approach that the AMA and others have been advocating for several years.

HCFA had published a Notice of Proposed Rule-making on May 3, 1996 explaining the RUC's five-year review recommendations and HCFA's response. Another Proposed Rule was published on July 2, 1996, addressing changes in payment locality definitions and a number of payment policy changes, including coverage for diagnostic tests, payment for transportation of EKG equipment, and separate payment for several integumentary system codes. The Final Rule responds to comments received on the May and July proposals and indicates HCFA's final decisions on the relative values for 1997, locality definitions, and policy changes.

In addition to the five-year review, the RBRVS Rule also describes the RUC's recommendations on the relative values to be assigned to new and revised codes for CPT 1997 and proposes "interim" relative values for these codes. A separate Final Rule, also published in the November 22 Federal Register, provides the 1997 Medicare conversion factors and the Medicare Volume Performance Standards (MAPS). Only the Rule containing the 1997 RBRVS Fee Schedule is open to public comment; no comment period is provided for the conversion factor Rule. Key provisions of both Final Rules are summarized below.

1997 Payment Update and Budget Neutrality Adjustments

Concern had been expressed that a new law requiring that major regulations be provided to Congress 60 days prior to implementation might mean the payment update would be delayed past January 1. The new relative values and conversion factors will, however, be in effect for services provided on or after January 1, 1997. HCFA concluded that a delay in implementation would be contrary to the public interest.

The 1997 Medicare Volume Performance Standards (MVPS) and conversion factor (CF) updates are based on formulas used in those years when Congress does not set the updates, and reflect a 2.0% increase in the Medicare Economic Index (MEI). The 1997 updates are:

	1996 CF	CF Update	Bud. Neut. Adjustment	1997 CF	1997 MVPS
Primary Care:	$35.4173	2.5%	-1.5%	$35.7671	+4.5%
Surgery:	$40.7986	1.9%	-1.5%	$40.9603	-3.7%
Other:	$34.6293	-0.8%	-1.5%	$33.8454	-0.5%
Anesthesiology:	$15.28			$16.6800	

Although this Final Rule does not address changes in the fundamental MVPS system, the AMA strongly believes that changes are needed immediately in the flawed MVPS formula. This formula, as modified in the Omnibus Budget Reconciliation Act of 1993, calls for physicians to reduce annual growth in the volume of services provided to Medicare beneficiaries by four percentage points each year. The result is projections for annual conversion factor cuts of 2-3% each year after 1997. In its recommendations to the Congress for the 1997 MVPS, the Administration had made a recommendation for a fundamental change to the MVPS. Although the AMA supports the basic framework proposed by the Administration, which also included the Medicare budget provisions passed last year by the Congress, we do not believe that either the Administration or Congressional paroposals thus far would provide for fully adequate conversion factor update levels. The AMA is refining a proposal that would provide physicians with a full MEI update if volume was held to realistic levels that still provided the federal government with budgetary protection.

In the RBRVS Fee Schedule Rule, HCFA describes two adjustments made for budget neutrality. All conversion factors have been reduced by 1.5% to account for payment policy changes, new procedures, and projected utilization changes due to the five-year review. Changes in relative values resulting from the five-year review were were also projected to increase Medicare expenditures for physician work by 8.3%, thus leading HCFA to make a second budget neutrality adjustment. For the first time, instead of reducing all relative values across-the-board by 8.3%, HCFA established a separate adjustment factor to be applied to the physician work relative values for each code. This means that (1) the only 1997 relative values that will be different from 1996 are those that were changed during the five-year review, and (2) other payment systems adopting the Medicare RBRVS will not need to also adopt Medicare's stringent budgetary constraints.

HCFA notes in the Rule, however, that the separate adjustment factor is

"temporary." In the future, HCFA may return to its previous policy of making such adjustments in an across-the-board manner to the relative value units.

Refinement of Relative Values from the Five-Year Review

HCFA received nearly 3,000 comments on 133 codes plus all anesthesia services in response to the May 3, 1996 Proposed Rule. The Proposed Rule indicated an acceptance rate of 93% for the RUC recommendations that had been submitted in 1995. Many of the comments addressed the 7% that were not accepted. HCFA convened multidisciplinary refinement panels in August to evaluate the comments and help determine final relative values for these services. Of the codes addressed in these panels, the relative values for 60% were increased, for 13% were decreased, and for 27% were not changed.

In addition to the refinement panel process, HCFA also considered a revised RUC recommendation to increase the relative values for anesthesia services, which was accepted, and comments supporting the RUC-recommended increases for the psychotherapy codes, which HCFA indicated in the Proposed Rule it had not accepted. (The anesthesia increase in the work relative values was reflected in the conversion factor increase for these services above the update that would otherwise apply.) The Final Rule indicates that HCFA has now accepted the increases for the psychotherapy services. The CPT codes for psychotherapy will not be payable by Medicare, however. Instead, HCFA has established 24 new alphanumeric codes as part of HCPCS Level II for reporting psychotherapy services to Medicare. HCFA believes that there are many different types of psychotherapy and that the variations in physician work, for example, between inpatient and outpatient psychotherapy services, are not sufficiently defined in the current CPT codes. HCFA views the alphanumeric codes (G0071-G0094) as temporary and plans to request that CPT adopt these changes in the future so that the HCPCS codes can be eliminated. The RUC-recommended relative value increases will be reflected in those new HCPCS psychotherapy codes which include medical evaluation and management.

Although the AMA is pleased that the recommended increases were accepted, we are very concerned about the process HCFA used in establishing separate alphanumeric codes. The AMA, HCFA, and the specialty societies have maintained a close working relationship in updating CPT and the RBRVS, yet neither the CPT Editorial Panel, the AMA, the RUC, nor the American Psychiatric Association was informed about HCFA's plans prior to the release of this Final Rule, and the medical community was given no opportunity to review and comment on the proposal. Although psychiatric practices will have to make significant adjustments in their coding and billing processes as a result of this change, one month is clearly insufficient to even educate them about what the changes are, let alone to prepare administratively to deal with them.

HCFA has made final the work relative values for evaluation and management services that were proposed in May. In discussing these services, however, HCFA outlines its plan to replace CPT code 9937S for care plan oversight with three HCPCS Level II

codes (G0064-G0066). HCFA justifies this change by stating that physicians frequently use the CPT code to report oversight services that are not provided to beneficiaries receiving Medicare-covered home health or hospice benefits, and are thus not covered by Medicare.

The Evaluation and Management Component of Global Services

Comments had been submitted by the AMA, the RUC, and many specialty societies in response to statements in the Proposed Rule that HCFA did not believe the relative values for the postoperative portion of global surgical procedures should be increased to reflect the increases for the evaluation and management service codes. In the Final Rule, HCFA indicates that no adjustment is being made for 1997, but that it will reevaluate this issue for the 1998 RBRVS and consider data and a recommendation from the RUC. One exception for 1997 is a small increase in the relative values for the delivery codes (59400-59622), reflecting increases in the individual visits included within these global services.

Refinement of Relative Value Units for New and Revised CPT 1996 Codes

HCFA received comments on the interim relative values assigned to approximately 50 CPT codes that were new and revised in 1996. These comments were evaluated by refinement panels with the result that the final relative values for 27% of these services were increased above the interim levels, including 50-100% increases in the relative values for spinal instrumentation codes (22840-22847).

HCFA had also reviewed the entire physical medicine and rehabilitation section of CPT. The majority of the therapeutic procedures will be at the level originally recommended by the RUC's Health Care Professionals Advisory Committee (HCPAC), although the lower HCFA-established values for occupational therapy procedures are being retained.

HCFA's Review of RUC Recommendations for CPT 1997

With a few exceptions, there was a moratorium on proposals for coding changes for CPT 1997 to accommodate the five-year review. One of these exceptions was coding issues referred by the RUC to the CPT Editorial Panel as a result of its review of the relative values for some procedures. The RUC submitted work relative value recommendations for approximately 90 new and revised CPT codes for CPT 1997, with many of the issues arising from comments submitted during the five-year review. HCFA accepted 87% of them. The RUC HCPAC also submitted 11 recommendations, of which eight were accepted, including the recommendation that the new codes for chiropractic manipulative treatment be assigned the same work relative value as osteopathic manipulative treatment.

Locality Changes and Payment Policies

Payment localities were determined by the Medicare carriers in 1966 based on their knowledge of local charge patterns, and they have changed little since that time. In response to comments received over the years advocating a more consistent

approach and a reduction in payment differences between adjacent areas, HCFA will implement the proposed changes in Medicare payment locality definitions described in the July 2 Proposed Rule (Option I i). This approach will restructure subcounty payment areas and combine localities within states to reduce the number of payment localities from 210 to 89 and increase the number of states with statewide payment areas from 22 to 34. For states that currently have multiple localities, HCFA did this by developing a weighted composite of each locality's work, practice expense, and professional liability insurance cost Geographic Practice Cost Indices (GPCIs). This weighted average is referred to as the Geographic Adjustment Factor, or GAF. The GAFs within each state were then ranked from highest to lowest, and comparisons were made between localities with higher and lower GAFs. Where the highest locality's GAF was 5% greater than the lower GAFs, localities remained distinct. If none of the locality GAFs exceeded the other locality GAFs by 5%, the state became a statewide locality. In addition, HCFA restructured all subcounty localities so that complete counties could serve as the basic locality structure.

The AMA has generally supported this approach, but continues to object to HCFA's use of proxies in place of data on the actual unit costs paid by physicians (e.g., staff salaries per hour and rents per square foot) in the GPCIs and locality definitions. HCFA should initiate the research necessary to support such refinements in these data. In its comments to HCFA on the July proposal, the AMA also expressed particular concern with the relatively large payment reductions in some mid-size cities (e.g. Austin, Texas and Rockford, Illinois) and asked that HCFA consider revisions to its methods to deal with this problem. It did not do so. The new GPCIs will be effective in all states except Missouri and Pennsylvania in 1997. Because Missouri and Pennsylvania contain localities whose GPCIs decrease by more than 4% under these changes, they will be phased in over a two-year period.

The July 2 Proposed Rule also outlined a number of payment policy changes. HCFA's final decisions on these proposals are outlined below:

- HCFA will only cover diagnostic tests ordered by the physician or non-physician practitioner who treats the patient, unless it is a physician who orders an x-ray to be used by a chiropractor to demonstrate subluxation of the spine. The AMA had recommended that HCFA modify this policy to ensure that its implementation would not eliminate coverage for medically necessary services. HCFA has clarified that the intent of the policy is to assure that the physician who orders tests for a patient is responsible for the management of some aspect of the patient's care.
- HCFA will assign HCPCS Level II code R0076 Transportation of EKG equipment a bundled status to indicate that this service is covered within the practice cost relative values for EKG services. Separate Medicare payment may be made only for transportation of equipment for x-rays and diagnostic mammograms furnished by approved suppliers of portable x-ray services.
- No separate payment will be made for 97010 Application of hot or cold-packs to one or more areas, which

will be bundled into the payment for other services.

• HCFA will not implement its proposed policy to cease paying separately for the intermediate and complex repair codes (12031 through 12057 and 13100 through 13152) when billed in conjunction with the excision codes (11400 though 11446 and 11600 through 11646). The AMA had opposed this policy. HCFA has developed new definitions for simple and intermediate repairs, however, and will follow these definitions while working with the CPT Editorial Panel to incorporate them into CPT.

• HCFA modified its proposal to establish alphanumeric codes for skin lesion destruction and agreed with AMA and other commenters to maintain the active status of CPT codes 11050 through 11052, 11200, 11201, 17200, and 17201. These codes are currently under review by the CPT Editorial Panel. Codes for the destruction of benign or pre-malignant lesions will be consolidated into one series of HCPCS Level II codes, regardless of body location, and HCFA will not recognize CPT codes 17000 through 17105. The AMA had commented that a proposal had been submitted to CPT by the American Academy of Dermatology and it would be more appropriate for coding revisions to be reviewed by the CPT Editorial Panel.

• No separate payment will be made for 94150 vital capacity, total. Medicare payment for these measurements will be bundled into the payment for evaluation and management services.

• HCFA will no longer cover 10 phonocardiography and vectorcardiography diagnostic tests (CPT codes 93201 through 93222). These codes were also deleted from CPT for 1997.

• A reference to programs that are recognized as an "approved medical residency programs" has been added to the definition of an approved residency program for purposes of the teaching physician rules to be consistent with the definition used in the direct medical education rules. The regulations text for Medicare A and B will now reflect a common definition of approved graduate medical education programs. The AMA had opposed this HCFA proposal and argued for allowing programs to choose between two residency program definitions. HCFA will also delete the reference to gender in the primary care exception criteria to the physician presence criteria for services billed to Medicare. The AMA supported the latter revised definition.

• HCFA will not implement its proposal to change the global periods for four percutaneous biliary procedures (47490, 47510, 47511, and 47630) from 90 days to 0 days. The 90 day global period will be maintained and HCFA has accepted the AMA comment to refer the issue of the work relative values to the RUC for further review.

The text of both Final Rules is available on the AMA Electronic Network. The Rules also explain how to download the complete regulations from the Internet. In addition, this Internet site may be reached from the AMA Home Page.

A limited number of copies of the Rules are available from the AMA. To obtain one, please call Robin Russell in the Department of Physician Payment Systems at 312-464-4736.

Paralyzed with Golf

*Stephen G. Lauten, M.D.**

He arrived on the first tee at Lakewood decked out for scratch golf, shoes and all. The only difference between Earl and anyone else was his pint-sized custom golf cart with no top. Oh, yeah, Earl Monroe cannot walk or stand up either. He's paralyzed from the nipples down. It happened on a vacation trip to Cancun over 10 years ago. A virus. A bad actor. Transverse myelitis. Instead of feeling sorry for himself, he changed careers and said goodbye to dentistry (an endodontist) and hello to an M.B.A. from the University of South Alabama. He's a financial consultant/planner now; one of the best I know.

He started playing paralyzed golf 12 months ago. His first shot with me as a playing partner was 10 days ago. I had no idea what to expect. Earl swivelled in his specially designed cart and, while still sitting, expertly maneuvered his clumsy legs to address the ball properly. A special tee similar to a circular place-kicker's tee but designed to fit a golf ball was placed between the tee markers with the shaft end of his driver. His initial shot was 4 inches off the ground and disappeared into the marshy lake 30 yards in front of us with a muddy thud. He told me he got nervous on the first tee. The fact that we were the only two people around did not matter, he said. He still was a bit nervous. I gave him a mulligan. Watching him made me feel sorry for my friend of nearly 20 years. This was really too hard for him.

His second tee shot (the mulligan) quickly changed my mind. With perfect tempo and with his 3 wood "Billy Club" at level parallel on the backswing, Earl hammered the Titleist ball 210 yards down the left center of Azalea's first fairway. We laughed. We reminisced. We shot the bull. I almost forgot that Earl was paralyzed until he drove his mini-cart onto the green. He putted out and we moved to the second hole. The only time I helped him was retrieving his ball in the deep bunkers. He can hit a trap shot; but, heck, it slowed us down too much, he related.

Earl can hit a 7-wood as sweet as any 5-handicapper and easily shot a 95 that Sunday afternoon. But the score did not matter. It was one of those wonderful early fall days when the wind was brisk in our faces and squirrels were gathering acorns under stately Spanish moss oaks. Almost no one was on the course; mockingbirds were chirping and chasing each other; and friendship felt like a warm hunting camp fire. I had watched my friend play golf using only one arm (it's easier that way), driving and chipping his shots directly at the hole with near-perfect timing and balance. Consider the U. S. Open champion. Consider the Master's champion. Consider Dr. Earl Monroe, my friend, the *real* champion.

*1720 Springhill Avenue, Suite 100, Mobile, AL 36604.

ALLIANCE

Mrs. John O'Toole
A-MASA President

How The Alliance Helps Doctors

This article will focus on what the Alliance does for you, the physicians of Alabama. Alliances, working with their Medical Societies throughout the state, send a clear and loud message that the medical community is a team united in our dedication to improving the health and quality of life for our communities.

The following article is provided by Ruth Lichtenfeld, R.N. She is the Health Projects Chairman for the state of Alabama.

The Youth Survival Card Program, jointly sponsored by MASA and AMASA, has been extremely successful and because of the many requests, has been expanded this year to include all private and parochial schools in the state. This card, made available to all 7th graders, lists the 1-800 numbers of most major national crisis hotlines which are operative 24 hours a day. The project has received superlative evaluations and an enthusiastic endorsement from Lt. Governor Don Siegleman's office. Last year over 62,000 cards were distributed and several personal stories related in the follow-up evaluations attest to the positive impact this program is having on Alabama teenagers.

In September, the Alabama Department of Public Health presented a workshop to Alliance members to certify these members as speaker/trainers on the subject of breast self-examination. Currently, members across the state are speaking to groups at churches, synagogues, P.T.O.s, garden clubs, bridge and tennis groups, teachers in-service, and various office staffs including those in physician's offices. In addition to this, we are working with the American Cancer Society on the state level to help provide certified volunteers to speak to every high school girl's P.E. class.

BREAST CANCER: AN ANCIENT DISEASE

Test your knowledge of the history of breast cancer. The date of the first description of breast cancers 3000 B.C.E. The earliest form of treatment? None, it was thought to be incurable. The beginning of present day treatment philosophy? The 1850s. Most of the recorded history of the diagnosis and treatment of breast cancer has involved the understanding of the actual disease and subsequent treatment.

It's description in the earliest medical literature indicates that breast cancer has always been the relatively common and virulent entity which we know

today. Imhotep, believed to be the first known physician, described breast cancer in documents thought to date from 3000 B.C.E. to 2500 B.C.E. The ancient Greeks had many writings concerning breast cancer. Hippocrates (460 - 370 B.C.E.) was the first to distinguish between benign and malignant breast neoplasm. He advocated no treatment since he felt medical treatment caused a "speedy death" and therefore to omit treatment prolonged life.

Roman scholars during the period 30 B.C.E.-38 B.C.E. showed remarkable insight into the natural history and evolution of breast cancer and extensive surgery was commonly carried out. One scholar, Celsus, indicated the benefits of early detection and treatment as well as the dangers of surgery for advanced cancer. These principles were ultimately confirmed 2000 years later. Greek physicians (130 A.C.E.-180 A.C.E.) were the first to view breast cancer as a systemic disease and recommend excision of the breast through normal tissue. This practice of performing mastectomy persisted largely unchanged for the next 1500 years. Substantial progress was made in these ancient years in understanding the process of breast cancer and in developing some of the basic surgical principles still followed today.

Unfortunately, over the next several centuries, progress was severly hindered and some key concepts forgotten. During the Dark Ages, the influence of the church on scholarly matters caused the banning of surgery for breast tumors because it was a "barbarous practice."

In the Renaissance period, many of the principles that eventually led to the modem era of breast cancer treatment were rediscovered or developed but progress was slow. Treatment included applying frogs, chickens, goat dung and the ever popular "bleeding." One physician to Queen Elizabeth around 1600 recommended "laying on of hands by the Monarch" to curb the disease. The 16th and 17th centuries provided further advancement in mastectomy techniques. This resulted in quicker and more thorough operations in an age without anesthesia. By the mid 19th century, the basic principles for the surgical treatment of breast cancer had evolved but many prominent physicians still believed that breast cancer was a "hopeless disease" and recommended against surgery.

The development of general anesthesia and antiseptic technique led to the re-emergence and popularity of radical surgery around 1882 and a more rational approach to management. These principles are still in use today.

Early treatments of breast cancer were not limited to surgery. Xrays were used to shrink tumors as early as 1906 and were also used to induce an artificial menopause in the hopes of altering the hormonal balance. Radium needles were developed and inserted into the tumor in the 1920s. Drug therapy has gained a place in treatment since the 1950s and continues to evolve.

This brief historical overview attests to the ubiquitous nature of breast cancer. Modem treatments have vastly improved the survival rate from what was once felt to be an incurable disease. Early detection remains the cornerstone of treatment. This can be accomplished by monthly breast self-examination, routine mammography per the American Cancer Society guidelines and yearly clinical evaluation by a physician.

Ruth Lichtenfeld, R.N.
Health Chairman, State Alliance

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MASA REVIEW

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MASA REVIEW

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Dr. Curry, Happy Warrior

By William H. McDonald

If you were not present at annual session in April, you missed an eloquent, albeit astonishing, speech by the 1997-98 president of MASA, William A. Curry, M.D. (See page 8).

At a time when many of his fellow physicians bemoan their lot, badmouthing what the profession has become under the scourge of predatory commerce, and all but swearing by Apollo that no son or daughter of theirs would ever study medicine, here was a doctor actually singing paeans of thanksgiving for all the gifts the profession has brought to him.

Here was a physician who had returned 17 years ago to Carrollton, the small West Central Alabama town of his birth, after splendid state-of-the art training at Vanderbilt — despite warnings that to do so was to embrace medical Siberia, and with it the nullification of most of the advanced knowledge he had acquired.

Had his listeners also known, as most did not, of the twin tragedies that had tested the mettle of Bill Curry during the years of his practice in rural Pickens County, they might have been awestruck by the certitude and tenacity of his faith as reflected in his words.

His return to Carrollton was dictated by requirements of the National Health Service Corps scholarship he had accepted for the last two years of medical school. He had obligated himself to practice in an approved physician shortage area. Pickens County, with only four doctors then for 21,000 souls, more than qualified.

He was resigned to his fate: "I accepted the conventional wisdom that I would never be able to put my excellent education and training to full use in such a small place."

Characteristically, he turned this adversity into a personal victory: "I used everything I'd been taught and then some," he says now.

But fate was to inflict on the character of Bill Curry far more punishing blows than the isolation of small town practice. In 1982, he and his wife, Julie, lost their son, John Walter, age 11 months, to adrenal cancer. Nine years later, Julie herself died of breast cancer at age 38.

Nothing is more devastating to the healer than the inability to save his own loved ones. Only a profound religious faith saved Bill Curry from annihilation by such crushing losses.

There may be an analog, in macrocosm, for what could be his greatest gift: his capacity, possibly congenital but certainly durable, for accepting adversity as a challenge, eventually pulling victory from the jaws of what would have been certain defeat in many others.

In the monumental 12-volume work, A Study of History (1934-1961), British historian Arnold Toynbee meticulously scrutinized 26 civilizations and the reasons for their success or failure. The primary mechanism he found in their genesis, triumph or disintegration was

"Challenge & Response."

The initial challenge might have been environmental (climate, geography, soil) or human (an ethnically divided population, bellicose neighbors). But in the end a civilization's survival invariably depended on its ability to respond to challenges, old or new, natural or man-made, Toynbee argued. Conversely, civilizations failed because, in the end, they could not find within their culture the moral stamina and faith to respond effectively and creatively to their challenges. They had the wrong stuff.

Toynbee's Challenge & Response hypothesis seems an apt metaphor for Bill Curry's life. Somehow, driven by mysterious inner sources of strength and resolve, he has not only survived, he has prevailed. Surmounting his deep grief over the loss of Julie and John Warner, for example, is this measured statement:

"These losses still weigh heavily on me, but we had a lot of happiness too. I learned a lot from them and am still learning. In the end, faith was the gift that sustained me. Since then God has blessed me with Glenda; we've just marked our second anniversary. Our daughters — Laura, rising sophomore at Tulane, and Seana, rising high school senior — are a delight. I consider myself the most fortunate man on the planet."

["Glenda" is Glenda Curry, Ph.D., President of Troy State University in Montgomery. They were married in 1995.]

For that earlier example of Dr. Curry's dauntless rejection of adversity, go back to the late 70s, his early days of practice in Carrollton, when he was not supposed to have an opportunity to use his education and training, as he had been told, and as he at first believed:

"The opposite proved true, though. I used everything I'd been taught and then some. I found I enjoyed it, that I could be a classic internist, covering as much as I could handle, relying on a good history and physical exam, since much of the ancillary equipment was 40 miles away in Tuscaloosa. There was the deep satisfaction of making a difference. And there was the security of raising a family in a supportive, family-oriented community. It was a great bargain."

These 17 years later, Dr. Curry felt he would leave Carrollton and pursue new horizons. He recently accepted appointments as Chairman of the Department of Internal Medicine and Interim Associate Dean for Clinical Affairs at the University of Alabama College of Community Health Sciences in Tuscaloosa, and Assistant Dean for Rural Health in the University School of Medicine as a whole.

Carrollton has come a long way since his arrival in 1979. He leaves it now with 17 physicians practicing there, a successful and effective hospital and health care system, CT, nuclear cardiology, part-time MRI, teleradiology and a fine lab — the fruits, in no small measure, of his own commitment.

"The success of the medical community in Pickens County is as good an example as I know," he says today, "of shared vision and clear priorities, not only from the physicians and administration, but from the people of the community. Literally hundreds of people have made significant contributions to that success."

To MASA's 1997-98 President, the glass is never half-empty but half-

full, and he'll handle the rest of the filling. His buoyant optimism, courage against all odds, and his dogged persistence, though hell should bar the way, can only be described as cosmic — all deriving from his abiding faith in the Almighty.

Science may never isolate the wellsprings of such a spirit, but one thing is clear: it's highly contagious, as patients, colleagues and neighbors quickly discover. So, those physicians who treasure their prophecies of gloom and doom would be well advised to give him a wide berth. Their pessimism is at risk.

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The Gifts of Medicine

Remarks of William A. Curry, M.D., at Installation as MASA President, April 11, 1997

As I considered what to say to you tonight, I planned at first to outline our agenda as an association for the coming year: Board and administration matters, member services, public policy. I decided not to do that. Instead, I want to describe for you what I believe to be the values that historically underlie and must underlie any actions we take. Medicine faces threats and challenges today, both to our credibility and to our effectiveness. If we are to address these, we must remember who we are and where we came from. So, first, I want to tell you about gifts, then about loneliness.

First, gifts. Perhaps as I tell you of my gifts, it will remind you of your own. In my life, I have had many remarkable gifts. Certainly, one has been my family, some of whom are able to be here tonight. I have learned, through joys and trials, what a gift it is to be a member of a loving family. The same can be said of friendships, and many special friends have joined us tonight.

My practice of the past 17 years in rural West Central Alabama has been a great gift, and an amazing journey, into the most intimate experiences of the people who have allowed me into their lives as their physician. There is for me a special closeness to them and to God, as I stand at the bedside at times of crisis and death, rediscovering every time the unique priestly role of the physician. None else can fill that role, and it is a role we must never forget or relinquish. There is also the surprise of explaining a very simple problem to a patient, only to see the flash of insight spread across her face, knowing that for the first time, she understands her fear. There is the joy of sharing the negative biopsy report, the celebration of successful doctor-patient collaboration in controlling a wild blood sugar, or the simple satisfaction of relieving a sore toe. I am happy to report too, that, at least in rural Alabama, there is still a lot of sharing of the vegetable crop in summer, and a rich spread of holiday food at Christmas. People still bring very tangible gifts to their physicians. There is, in short, the gift of the eternal drama of human life, death, and relationships. They are our "pictures at an exhibition," our walking novels to read every day.

It has been my special opportunity to engage these relationships in our community as we have developed a system of health care. It was these relationships, through hospital, public health, university, and governmental affairs, that prompted me to be involved in organized medicine, as a logical extension of my practice and my community involvement. This, too, has been an abiding gift.

I have had the gift of teaching, too. First, as all of us doubtless can say, I was blessed with some great teachers. Throughout my practicing

career, through the generosity of the University of Alabama College of Community Health Sciences at Tuscaloosa, I have had the gift of working with medical students and residents. Of all that Sir William Osler did as the father of modern medicine, it is said that his epitaph was that he taught junior medical students on the wards. There could be no greater epitaph, for it is the best way we have to pass the torch, to share the heritage with those who will follow us. Teaching has been for me a great gift, indeed.

Now you do me the great honor of allowing me to serve you as President of this association. I cannot express to you how deeply honored I am, and how humbled I am, as I hope to represent you well. Perhaps it will begin to explain it if I say that all I have said until now, the gifts of family and friends, of medical practice, of community, of teaching and mentoring, all are wrapped up in the package that I see myself accepting as your President. Tinsley Harrison, arguably the father of modern medicine in Alabama, very aptly said that no greater privilege can be given to a human being than to serve as a physician to his fellow human beings. How much greater privilege can there be than to represent you who carry the torch every day? Surely, we all carry that torch higher some days than others, and there are days we stumble and occasionally even fall. That is the nature of life and it is the nature of medicine. What remains, what sustains, are the relationships with our patients and with one another.

I want now, as a preacher might say, to begin to close, by sharing a story about such relationships. I should warn you that where I come from, the beginning of a closing is still a ways from going home. The story involves Dr. William E. Hill, of Carrollton, who has the dual distinction of having been a recipient of this association's Samuel Buford Word Award, and also of being my family doctor when I was growing up. In that latter role, he was my role model for being a physician. Shortly after I came home to practice in Carrollton, Dr. Hill called me out to the intensive care unit at about two a.m., to consult with him on a difficult patient. It was in that setting that he told me this story of his father, Dr. Hugh Hill.

It seems that when Dr. Hugh came home from training in Mobile to practice with his father, he was eager to share the technological wizardry of 1905 with the older physicians of the community. His opportunity arrived with a call late one night to join Dr. Charles Murphy on an OB case. Dr. Hugh hitched up his horse and travelled fifteen miles or so on unpaved roads, then across a cotton field to a sharecropper's house. So it would be here, in this humble place, the young doctor thought, that modern scientific medicine would come in full glory to Pickens County, Alabama.

There in the front room was Dr. Murphy, finishing off a bowl of buttermilk and cornbread. He motioned to the back room. "She's back there, Hugh; check her out and tell me what you think." The young Dr. Hill followed the older doctor's directions and in a few minutes, he returned to the front room. "Well, Dr. Murphy," he said, "this is her first baby, and she's still in pretty early labor. The position seems fine, and she's progressing, but I think it's going to be a while before we have a baby here." To himself, he thought that the older doctor might just

be losing a little of his edge; this seemed too easy.

Then Dr. Murphy replied, "Oh, hell, Hugh, I knew that. It's just that sometimes it gets lonesome 'way out here." Now as Dr. Hugh's son William was telling this story to me, it was clear that my situation was similar to the younger doctor in the story. I had just come from Vanderbilt with the light of high technology. I, too, had been called out in the middle of the night, not to a cotton field, but to an ICU. As we stood there, Dr. Hill said very kindly, "I want you to know that it's not the only reason I called you out here tonight, but it does get lonesome sometimes."

Now that's all very quaint and amusing, but what does it have to do with the practice of medicine in 1997, or with the challenge of running a state medical association? Just this: It still gets lonesome out here sometimes. There may be 6,000 MASA members now, a far cry from the 21 hardy souls who gathered in Mobile in 1847 to found this association, and we may be members of group practices themselves far larger than 21 doctors. But in working hard to do the best we can with every patient, it gets lonesome. Watching what looks sometimes like a tidal wave of managed care, regulation, consumerism, and malpractice threats, it gets lonesome. Listening to business people claim that you and I are driven by the desire to maximize income, it gets lonesome. Struggling to stay up to date with stacks of journals, newsletters, audiotapes, and meetings, it gets lonesome. And sometimes we're surrounded by colleagues who are just as stressed and just as overwhelmed with details as we are, and we find that when we talk, it never is about things that are really important. That's lonesome, too. Like the lyrics of the "Lonesome Boy Blues," we have found that "Lonesome's a bad place to get crowded into."

How do we get lonesome like that? I'm sure it's more complicated than I understand, but I believe this much: There's obviously a lot more to it than geography. When we become isolated from patients, or from each other, we get crowded into being lonesome. And that brings us to the most fundamental role of organized medicine, no different now than in 1847: As physicians, our first duty is to the welfare of our patients, and our second is to taking care of each other. As an association, if we don't remind each other of those two obligations, we don't deserve a future. So long as we do remember them, in the long run, there is no managed care organization, no trial lawyer, no government that can long prevail.

And what about the future of the Medical Association of the State of Alabama? There are those who say that in the age of managed care, the provider panel will replace the state association. If so, God help us, and especially, God help our patients. While we are redefining the role of MASA, that is nothing new. That has been going on for 150 years. In fact, we are redefining what it means to be a physician; that also is nothing new. We are welcoming a new Executive Director. Now, that is momentous. Lon Conner, to so many physicians and non-physicians has been the medical association. Clearly, Lon, we will miss you, but as all of us would hope to do, you have left a legacy of which we all are proud. Cary Kuhlmann, I don't have to tell you what big shoes you have to fill; you know that already.

What I do want to tell you is that I am excited at the prospect of working with you; as you look around this room, it is filled with people who want to help you succeed.

We will be working hard as a Board and Staff in the next year. Clearly, the transition in the Executive Director's job will be a dominant process, but I expect it to be smooth, given the character of the two men involved and the support of the Board. We must continue to look at the organization and function of our Board, as the scope and volume of our work is at times just as overwhelming as the practice of medicine in 1997. We must work smart as well as hard, or else we could work ourselves into irrelevancy as a Board. I am convinced we will find ways to re-invigorate the process, so long as we can count on the help of people like those of you here tonight.

And what about this gathering itself? It amazes me, year after year: 15 past presidents of the association, 38 members who have practiced medicine for 50 years, and the recipients of our highest awards. The ability, the courage, the energy, the wisdom in this room are what amaze me. And they are what encourage me. For all the overwhelming nature of the challenges and problems of the day, we share a profession that by its nature spends itself in life's toughest struggles. We don't know what the results will be. As Stonewall Jackson said, "The battle is ours; the outcome is the Lord's." We do know that it is in the struggle that we find significance; it is in the struggle that we find the relationships with patients and with our colleagues that are what really matter.

Fortunately, our roles do not always require comprehensive answers. That is the nature of medicine. We deal with one question, one pain, one crisis at a time. The aggregate of our efforts becomes our response to the needs entrusted to us, whether in the individual patient or for an entire state. That is the genius of medicine. In the struggle, through the relationships, there are unexpected discoveries, and the art and the science of medicine advance. More importantly, so long as we stay close to our patients and to one another, we make one other unexpected discovery: the whole is greater than the sum of the parts. It can be lonesome out there, but knowing that we're lonesome does a very good thing. It brings us together.

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The Last Column

By S. Lon Conner
Executive Director Emeritus

This is my last column after 21 years as Executive Director. Although I will remain on Board until the end of the year, on Aug. 1 the title passed to my successor, Cary Kuhlman, and I shall function the rest of the year in whatever capacity I can best assist a smooth transition.

Cary is abundantly qualified for the job; he has been the exec of the New Orleans Medical Society for the past 20 years and comes to MASA highly recommended by all who know him. He was selected from a list of some 50 impressive applicants as eoming closest to what the Association needs as it approaches a new century and a vastly transformed health care landscape.

Having served you during this transformation, I know the truth of William James's observation (in Psychology, Briefer Course, 1892):

"A time filled with varied and interesting experiences seems short in passing, but long as we look back. On the other hand, a tract of time empty of experience seems long in passing but in retrospect short."

I have served you 21 years, years that have been anything but empty of experience. Two full decades slipped by as your Officers addressed literally hundreds of complex challenges, most of them unprecedented. It has been said that the nature of medical practice changed more in this period than in the previous 200 years. Looking back, the battlefields seem to stretch to the very horizon of memory.

When I joined the Association in that long ago autumn of 1976, had I known what all lay ahead, I think I would have been forced to confess to the Board of Censors that I was not the Superman the times demanded. But somehow, with the support of all of you, we have pressed on, a foot slogging infantry that suddenly realizes it has traversed a continent, torturous mile by torturous mile.

I do not cotton to long goodbyes; I'll be around for the balance of the year in any case. I ask only two things: that you give Cary Kuhlman the support you have so generously given me; and that you remember Carolyn and me in your prayers, as we shall continue to remember you, always.

Laying no claim to the gift of prophecy, I do not know whether the years when I walked among you will someday be remembered as the good old days. But I suspect they may be, as fractious and divisive as these days have sometimes been. Time has a way of bathing even the most desperate moments in a warm, pink glow.

But of this much I am certain: the years 1976-1997 will always be the good old days for me. They already are.

Thank you and so long. It has been a high honor. Keep the faith.

—Lon

Tinsley R. Harrison, M.D., Teacher and Paragon of Internal Medicine[a]

by James A. Pittman, Jr., M.D.
Dean Emeritus, University of Alabama School of Medicine, UAB

Dr. Pittman, UAB Distinguished Professor, was Tinsley R. Harrison's last Chief Medical Resident, 1957-58. He is writing a book on Dr. Harrison and the Harrison medical family.

WATSON'S WIFE

In 1957, when the South was going through racial turmoil and was the poorest section of the United States in terms of economics, education, civil development, and medical care, and at a time when the first thing most wealthy local citizens did when they got sick was to leave the State of Alabama for care at the Mayo Clinic or Boston or New York — at this time, Cecil J. Watson, M.D., Chairman of the Department of Medicine at the University of Minnesota, one of the leading schools in the nation, brought his wife to Birmingham seeking medical care. Why did C. J. Watson, co-inventor of the Watson-Schwartz test for porphyria and a world leader in medicine, who could have taken his wife anywhere in the world, including the famous Mayo Clinic just a few miles from Minneapolis, why did he bring her to Birmingham?

The answer was Tinsley Harrison. Watson's wife had poorly defined chest pains, and nobody had been able to figure out the diagnosis. Tinsley Harrison was not only one of the world's great cardiologists, but also a superb general internist. In those days, not so long ago but well before our modern testing procedures, Dr. Watson decided this was the best place in the world to take his wife for this important diagnostic workup. And he decided that because Tinsley Harrison was here.

Some people understand the fundamental importance of having a good doctor!

BASIS OF HARRISON'S FAME

Tinsley Harrison was the most outstanding internist the South, and perhaps the entire United States, has ever produced and one of the world's leading internists of all time. He was born in 1900, so his age coincides with the years of this century. On Table 1 are listed the four main areas of his professional activities. **[See Table 1]**

His book, *Principles of Internal Medicine*, or PIM as his colleagues sometimes called it, was the critical item that made him world famous. That book first appeared in 1950, is now in its 13th edition (1994), and is available in at least 10 languages [(b)] (plus likely pirated editions in several other languages). But that book really only brought into a focus the many currents and rivulets that went into the creation of Harrison's whole life.

He was also the first Chief

[a]- Presented at Medical Grand Rounds, UAB, 17 March 1994. Copyright by James A. Pittman, Jr., M.D., 1997.

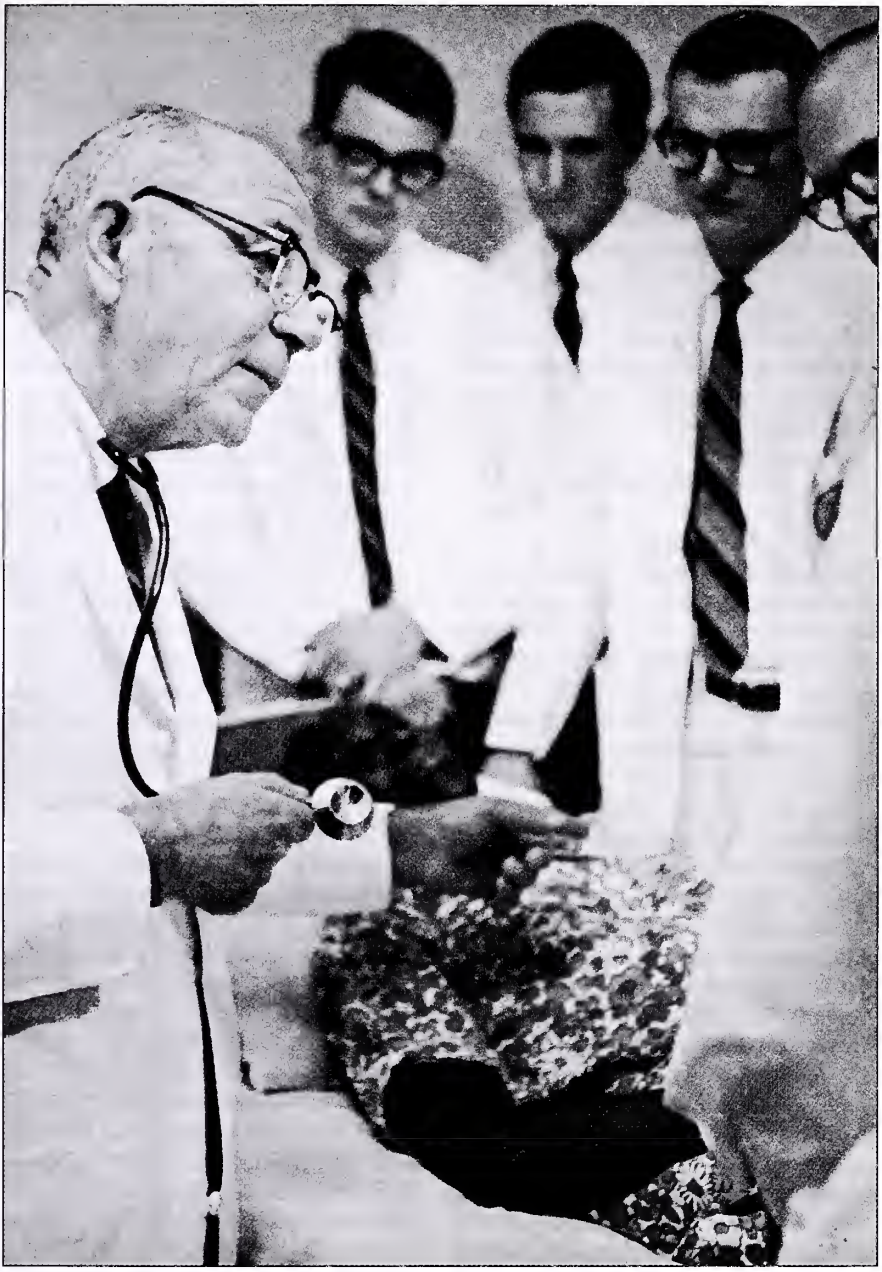


Figure 1 **Tinsley Harrison in a characteristic setting, with a patient as the center of attention, surrounded by medical students and house officers. This was probably in Birmingham in the late 1960s.**

Medical Resident at the new Vanderbilt Medical School in 1925 and the first chairman of medicine at 3 (three!) new medical schools, probably a record for the United States and perhaps a wider area. He was a leader in medical research and development of scientific medicine of the twentieth century. He was a superb and exemplary clinician, and late in life a bitter critic of the uncritical and excessive use of the high technology he himself had helped develop. But it was really in teaching that he was an all-time world champion.

BACKGROUND

In order to understand Tinsley Harrison, we must first understand his background. Table 2 lists some of the developments in medicine during the seventeenth and eighteenth centuries, leading to Tinsley Harrison's medical forebears at the end of the latter century.

Tinsley Harrison was a seventh generation physician. That is, his father, grandfather, great grandfather, and three more grandfathers before that were physicians.

All the Harrisons were colorful figures, and J.T. was no exception. Born in the James River region of Virginia, he fought with Andrew Jackson in the Alabama Indian wars at the age of 15, then helped survey the site for Huntsville, Alabama's first capital. He started medical school at the University of Virginia, but he became enamored of a young lady named Melinda Stone, of whom his James River family did not approve. So, in good Harrisonian fashion, J.T. married her anyhow and moved to the frontier in Tennessee, where both had relatives. There they found that his relatives were gamblers, saloon keepers, hard-drinking sportsmen, and generally a wild bunch. Hers, on the other hand, were the leaders of society, and one became an Alabama supreme court judge.

After a couple of years in Tennessee, they moved to Alabama, where he practiced medicine and farmed cotton. He farmed cotton to make money, since in the early nineteenth century people had a low regard for doctors, and most patients in this area were poor anyhow, even before the Civil War; so they paid by giving the doctor a chicken, or a pig, or produce. The location of the farm was at a place called "Harrison's Gap" **(arrow in Fig. 6)**. There was also a skirmish at Harrison's Gap during the war, 21 April 1864.

J.T., Sr., had two sons, both doctors. The younger, John Tinslev Harrison. Jr., born in 1834, first apprenticed with his older brother for a year or so, then attended medical school at the University of Nashville and obtained an M.D. degree.

19th CENTURY PRACTICE

What kind of medicine did J.T. Harrison, Sr., practice early in the century? Well, he had few tools other than his own physical senses and whatever common sense was permitted by the customs and theories of the times — no stethoscope, probably no percussion, perhaps no thermometer, but mainly he was restricted by a lack of a sound theoretical understanding of illness and health. The prevailing theories were humoral; that is, basically the same as Galen's nearly 2,000 years before! Some problems were fairly obvious, like a broken leg, but most complaints and illnesses were poorly understood. There were many variations, but the main underlying theory

was that disease is caused by an imbalance of the four humors of the body — yellow bile, black bile, blood, and phlegm. There were as many different diseases as there were individual sick people. The object of treatment was to restore the balance of nature, and if the diagnostic methods available to John Tinsley Harrison were primitive, the treatments were even worse — especially bleeding, which was supposed to rid the body of the excess of the imbalanced humor: Too much black bile piling up in the blood? Just drain it off with repeated bleedings! When President George Washington died some four months after the birth of John Tinsley Harrison, Sr., his doctors treated his sore throat with repeated bleedings. In fact, they removed lots of blood, perhaps more than two liters, and they probably bled him to death! That is, his doctors, the best in the land at the time, probably killed him with the treatment!

MODERN MEDICINE BEGINS

There were some smart physicians even in those times who questioned these theories and attempted other classifications of disease. While the Swedish physician Carl von Linne, better known to us as Linnaeus, was in medical school in Holland in 1734, he read a new little book by Francois Boissier de Sauvages of Montpelier, presenting a new classification of diseases.

Linnaeus was primarily a botanist, who later invented the genus-species binomial nomenclature used in biology today. But he also became Professor of Medicine at Uppsala, where he turned out many influential books, including *Genera Morborum*, his own classification of human diseases, in 1763 (**see Table 2**).

I've asked a lot of physician friends about "nosology," and most have never heard of it, or think it is a study of noses. This week I asked our fearless peerless leaders — our Chief Medical Residents — about this. I hate to shake your confidence in the leadership around here, but all of them, each and every one, disclaimed any knowledge of nosology (except Dr. Wassynger, who is out of town; maybe he knows). For reasons of personal security I cannot reveal the names of the professors I asked, in several departments; but all of them (except two) similarly said they knew nothing about this field. The two exceptions were Drs. Tom Huddle and Hughes Evans, both of whom have Ph.D.s in the history of medicine, as well as M.D. degrees. **(c)**

The word "nosology," and the concept, have appeared in the past few months in scientific articles in medical journals such as the New England Journal of Medicine, so it is still in current use.

What is nosology? A few points about nosology (sometimes called "nosography," which I would say is the writing on the topic) are shown in **Table 3**. Lest you get the idea that this is some sort of arcane antique subject of no relevance today, look at this next figure (**Fig. 7**), which shows the book ICD-9-CM, the International Classification of Diseases. 9th Revision, Clinical Modification. 4th Edition, 1994. Nosology is in fact how you get paid! And how most doctors these days get paid a large proportion of their charges! There are courses all over the United States on how to code for medical services to maximize reimbursement. And it is the basis of DRGs **(d)** and many other aspects of

modern medicine. It is the basis for understanding a disease and the very idea of what is a disease? Is the "gulf war syndrome" a disease? What about the various psychiatric diagnoses? Where do normal human variations and complaints end and diseases begin?

That was the situation when John Tinsley Harrison, Sr., grew up and later practiced at Harrison's Gap at the beginning of the nineteenth century, getting gratitude and chickens from patients and money from cotton. As for instruments, the stethoscope probably did not make it into Alabama until nearly mid-century, the 1840s or '50s. At the middle of the nineteenth century, the "forty-niners" migrating to California during the gold rush, carried copies of a nosology proposed in 1769 by the famous British physician William Cullen along with his advice on medical practice, *First Lines of the Practice of Physic* (1776-94). Despite the gathering momentum of the scientific medicine of the enlightenment, medicine was still pretty primitive just before the U.S. Civil War.

J.T. HARRISON, Jr., M.D. 1834-1915

Some of the developments in medicine during the nineteenth century are shown in **Table 4**, "Medicine in the Time of J.T. Harrison Senior and Junior."

John Tinsley Harrison, Junior, was born at Harrison's Gap on the north bank of the Tennessee River in 1834 (**Fig. 6**). J.T., Jr., started practice in his home area just before the Civil War, entered the Confederate Army as a doctor, was captured by the Yankees, negotiated a special deal (another Harrison characteristic) to care for the wounded in exchange for two things: first, he was permitted to wear gray trousers to identify himself with the South, and second, he was permitted to care for the southern wounded first, after which he gave the Yankees the best medical care he could. He made some friends among northern doctors, who remained friends all his life.

After the war he returned to the Harrison's Gap area to find his young wife dead and the South in ruins. Then in '68 Grant was elected President, and Reconstruction really began with a vengeance — a real vengeance.

Northern federal troops were stationed in the area, and one day J.T. was walking down the street in a village near Harrison's Gap with a farmer friend and his friend's wife. As they passed a northern federal officer, the officer made some suggestive wisecrack to the friend's wife. Her husband was a large and powerful man, and he struck the federal officer on the chin, and he went down. As he did he reached for his revolver, and the farmer kicked him in the face, whereupon his head was thrown back and hit the ground, and he died instantly. The three southerners left the scene very quickly, and J.T. gave his friend a horse on which to escape. He himself was then in trouble, so he took a horse and, on horseback and at night, swam the Tennessee River and headed south. There in east Alabama he remained, moving about, changing his name from time to time, and living at various inns or wherever he could.

Finally, after some weeks or months, he ended up as a guest in the house shown in **Figure 8**. The house was built in the early 1830s by Jared E. Groce, who operated a country store at the nearby crossroads. Mr. Groce had migrated to Alabama from South

Carolina, and his son had served in the confederate army. This house is a half-mile south of the village of Eastaboga, about 50 miles east of Birmingham. Behind the house is a small family graveyard containing about 20 graves, where the worldly remains of these members of the Groce family still reside. Here is the headstone for the graves of Jared and Sarah Groce, Tinsley R. Harrison's great grandmother and grandfather (**Fig. 9**).

While he was staying with the Groce family at Eastaboga, J.T., Jr., became enamored of the Groce daughter, Sarah Simmons Groce, and they were married in 1869. Mr. Groce gave his daughter Sarah some land a few miles to the west near Munford where there was already a small house, which remains today considerably remodeled and modernized.

TINSLEY'S FATHER

There in Munford in 1871, Sarah Groce and John Tinsley Harrison, Jr., had a son they named William Groce Harrison, Tinsley Harrison's father, whom they always called "Groce." As a child of six Groce was put to work in his father's cotton fields — planting cotton, chopping cotton, picking cotton. He was doubtless sick of cotton! (Which may in part have been his father's purpose.) He attended Auburn in 1887, where he roomed with the grandfather of C. Glenn Cobbs, M.D., now a Professor of Medicine at UAB. He graduated in 1891, then went to Tennessee, where he obtained an M.D. degree in 1892 from the University of Nashville Medical School, the same school where his father and uncle had studied. That school was one of the predecessors of today's Vanderbilt medical school.

Groce considered this M.D. a waste of time and money. The "one-year" school [e] was terrible. Medical science was burgeoning in Europe and northeastern cities of the United States, and there was an entirely new science, bacteriology (**Table 5**). Groce was probably vaguely aware of these exciting changes, but he learned little significant about them in Nashville. Therefore, he moved to Baltimore to obtain a second medical degree from the Medical College of Baltimore in 1892-93. **Figure 10** shows Groce as a young man in Baltimore at that time.

Groce is a fascinating story in himself. He was a friend of William Osler, published a number of papers, was offered the Chairmanship of Medicine at the medical school in Mobile in 1904, studied in Germany, hired a live-in German hausfrau to make sure Tinsley spoke German well, was President of the Medical Association of the State of Alabama, influenced his family tremendously toward medicine (no more cotton picking!), wrote an autobiography, and much more — but all that is another story.

During his year at the Medical College in Baltimore, Groce heard of a brand-new medical school being started across town, which he visited to learn more about. There he met William Osler and others on the faculty, who urged him to enroll in Johns Hopkins, which was going to start an entirely new type of medical education — based on scientific medicine. Late that spring in 1893, Groce Harrison, age 22 and already in possession of two M.D. degrees, did apply, was accepted, and was ready for another four years of education in scientific medicine. The first class of the new Johns Hopkins University School of

Medicine was set to begin that fall of 1893.

However, as happened so often in the Harrison family, a woman was fated to change the fortunes of Groce Harrison. That summer, with his two M.D. degrees, Groce returned to Auburn for a class reunion. There at the Presbyterian church he met a young woman who changed his life, Louisa Marcia Bondurant, daughter of the Dean of the Auburn School of Agriculture. To earn a living for marriage he abandoned further medical school and entered practice in Talladega, a few miles west of his parents' home near Munford. Later he and his father started the first hospital in town — four beds, no charity patients, because there was no way to pay for them.

Figure 11 shows a photo of the young couple participating in another wedding around the time of their own marriage. Groce and Louisa (whom the family always called "Lula") are on the extreme right looking fondly at each other. This wedding was that of Lula's sister Emily.[f] Thomas J. Jackson, an uncle of these two sisters and long dead at the time of this photo, was better known as "Stonewall" Jackson of Civil War fame. He had been a groomsman in the wedding of their parents, the Bondurants.

Groce and Lula, Tinsley Harrison's parents, were married in 1896, just after Roentgen and Becquerel in Europe discovered x-rays and radioactivity, respectively.

NEW CENTURY AND TINSLEY

Tinsley was born in this house (**Fig. 12**) in Talladega on March 18th, 1900. Groce had bought the house shortly after his marriage. It is now occupied by the man who was recently mayor of Talladega. When Groce bought it just before 1900, it was very modern and was wired for electric lights. However, the electricity was very unreliable, so it was also piped for gas lights. The house was not only Dr. Groce Harrison's home, but also his office, clinic, and operating room. The old operating room was on the left in this photo, on the second floor of the wing to the rear. Under it was the patient waiting area. Tinsley was probably born in a bedroom, since a woman then would not want her child to be born in an operating room. I don't know how the gas lighting worked with the open drop ether they may have used on occasion for surgery, but the house is still there, so they didn't blow it up! Probably they used chiefly chloroform and kept the place well ventilated.

Almost all medical practice in those days, certainly in this part of the nation, was conducted in either the doctor's home or the patient's home.

Thus, Tinsley Harrison was born just as the new twentieth century was getting under way, this last century of this millennium, and at a time when the basic groundwork had been laid for the wondrous accomplishments of American medicine during this century, a trajectory unmatched in history. They named him "Tinsley" after Groce's father and "Randolph" after some unknown maternal ancestor from Virginia.

Groce and Lula had five other children, one of whom died of congenital heart disease at age 16, probably tetralogy of Fallot, Tinsley's brother. All of these children, except the one who died at 16, either became doctors or married doctors! It was a medical family!

Table 6 lists a few of the events in

medicine between TRH's birth in 1900 and his graduation from medical school in 1922. Tinsley was a bright child and skipped three grades in grade school, completing high school at age 15. The photo shown in **Fig. 13** was taken on April 20th 1910, 76th birthday of J.T. Harrison, Jr., Tinsley's grandfather. It was a family gathering on the porch of the old Dr. J.T. Harrison farm near Munford, east of Talladega. On the left at the head of the table is the patriarch, J.T. Harrison, with his wife Sarah at the other end of the long table, the extreme right in this photo. Dr. Groce Harrison is the older man on the other side of the table facing us, and to his right is the young ten-year-old Tinsley in the dark suit with his younger (but larger) brother W.G. Harrison, Jr., in the white shirt seated between him and his father. There are three generations of Alabama physicians in this one photo, all in the same family.

Fig. 14 is a photo of old J. T. Harrison, Jr., which appeared in the local Talladega newspaper that day. He looks like a man who might have been involved in a fight then crossed the Tennessee River on a horse at night.

HIGHER EDUCATION

Tinsley completed high school at the age of 15 and wanted to be a lawyer. He was accepted into Harvard College, but in 1915 during the war cotton prices fell precipitously, and the money ran out. So he went to Marion Military Institute in Alabama instead. In 1916 he entered the sophomore class at the University of Michigan, which was considerably cheaper than Harvard.(g) At Michigan he did well enough for a completely elective senior year, and he elected medical school. So his last year in college was also his first year in medical school. In **Fig. 15** he is in the navy in 1918 at Michigan. To the right on the same page of the University of Michigan medical school yearbook that year was his classmate Walter Bauer. Bauer, a native of Michigan, went on to finish medical school there, was a lifelong friend of Tinsley's, and later became Chief of Medicine at the Massachusetts General Hospital and Jackson Professor of Medicine at the Harvard Medical School.

Tinsley loved Michigan and wanted to finish medical school there. It was an excellent school, and many of the original Hopkins medical faculty had come from there. But for Groce Harrison there was only one school, so Tinsley transferred to Hopkins and finished there in 1922, age 22. Here he is with some of his classmates as he graduated (**Fig. 16**).

He went next to the new (nine years old) Peter Bent Brigham Hospital in Boston, where he served as a house officer from 1922 to '24. These years were formative for two reasons: first, he published his first research papers then; and, second, he met many people who influenced and helped him the rest of his life, especially Sam Levine the famous cardiologist. But most especially he met a young nurse from the nearby Boston Children's Hospital, Elizabeth Woodward of Grafton, Massachusetts.

They were married in February 1924, and in July they moved to Baltimore, where he became senior assistant resident and she worked as a nurse. In November they had a son whom they named Lemuel Woodward Harrison. They called him "Woody," and he was the apple of their eyes — their firstborn and their first son, on

whom they built great hopes and expectations.

During his medical school years at Hopkins, Tinsley befriended the man he called "the best friend he ever had in the world outside his own family," Alfred Blalock, later Chief of Surgery at Hopkins and originator of the "blue baby operation" for tetralogy of Fallot in the 1940s.[h] Blalock was a fellow southerner from Jonesboro, Georgia, and he loved tennis, and so did Tinsley. Together they participated in many tournaments and were usually winners or near the top. But Blalock was not the scholar Tinsley was, and he did not obtain a Hopkins surgical internship in 1922. He did get a second choice in urology, which had a rotation through surgery. So he hung on, and in 1924-25 when Tinsley was a senior assistant resident in medicine, Blalock was spending a year as a "special extern" in ENT. By the summer of 1925 Tinsley had lined up a job as chief medical resident at the new medical school about to open in Nashville, Vanderbilt Medical School. But Blalock had no job at all. Dr. Crowe, his ENT mentor, finagled a sort of fellowship at the Brigham with Harvey Cushing. But the ever manipulative Harrison talked the Chief of Surgery at Vanderbilt into offering Blalock the chief residency in surgery. Blalock had just arrived in Boston when Harrison reached him at the Brigham by phone. He did not even unpack his bags, but went right back to the train station and left for Tennessee.[i]

THE VANDERBILT YEARS

Fig. 17 shows the Vanderbilt Medical School around the time Harrison and Blalock arrived "the same day in 1925." Vanderbilt was said to be the first place with the medical school, hospital, outpatient clinics, teaching and conference rooms, and research labs all under one roof, an accomplishment of their first dean, Dr. Canby Robinson and something many other American academic medical centers are still trying to achieve.

The original Vanderbilt house staff in 1925 is shown in **Figure 18**, with Tinsley in the center of the front row and Blalock to his left (our right).

In July 1926, after they had completed their year as chief residents, they became instructors on the Vanderbilt medical faculty. Harrison obtained a Rockefeller traveling fellowship and spent the year 1927-28 in Europe: Vienna, Austria (which he did not like; too big, too commercial, and too many Americans, with a spirit of post-glory disintegration in the air), Freiburg-im-Breisgau, Germany (which he loved), and Cambridge, England (where he gained valuable experience in best quality laboratory research). On this trip he learned much about European medicine and doing research in the dog lab, and he published several more papers in the process, one in German and one with the famous British physiologist Barcroft.

Then he returned to Vanderbilt and became an Assistant Professor. Here he is about that time with some faculty colleagues (Fig. 18, third from right on the front row).

Harrison's research productivity during his Vanderbilt years was prodigious. He had published five papers before reaching Vanderbilt, three from the Brigham and one in the *Journal of Clinical Investigation* with Blalock, all with people who remained lifelong friends and colleagues. At Vanderbilt he published dozens. One year he pub-

lished 13, five in the new and prestigious *Journal of Clinical Investigation*, the official journal of the new American Society for Clinical Investigation, the ASCI or "Young Turks. "

Canby Robinson, the Dean and Chairman of Medicine who hired Tinsley to Vanderbilt in 1925, later wrote that Tinsley was "a human dynamo," and that was accurate.(j) He made ward rounds with house staff and students, gave lectures, arranged and presented CPCs, ran all the clinical diagnostic laboratories, had special sessions with medical students, gave lectures for county medical societies and practicing doctors in the community, had students to his home for dinners and discussions, traveled extensively to meetings, and above all spent vast amounts of time and energy in the lab doing research and writing up and publishing results. By 1930 they had three children, and his salary was $3,500 annually.

In 1928, age 28, Tinsley was elected a member of the "Young Turks," the ASCI. This was really his first big step into academic medicine. What organizations are important here?

Table 7 shows the main organizations important for internists in an academic environment, then and now. However, if you are going to hang around a medical school as an internist, (or in fact around clinical medicine anywhere), you would do well to stay close to the practice of clinical medicine. **Table 8** lists some of the organizations important for internists who continue to see patients and do clinical practice, even part time, rather than diving into a laboratory full time.

Interestingly, the very term "internal medicine" in America might be considered to date from the 1880s, when the AAP (Association of American Physicians or "Old Turks," not to be confused with many other organizations with similar but not identical names) was formed in the United States. In 1886 the AAP began having meetings chiefly for internists interested in clinical research, as opposed to surgeons, ob/gyns, psychiatrists, pediatricians, etc. The German society of internal medicine began about five years earlier. Tinsley Harrison was active in these.

Table 9 lists some of the events of the 1920s as related to Tinsley Harrison.

As just mentioned, Harrison's income in 1930 was $3,500, a good salary for the time. However, he had a growing family, so he left the full-time faculty and entered private practice at the Burch-Eve Clinic in Nashville, where most of the other doctors were surgeons. He also continued his hyperactive schedule in the labs, on the wards, lecturing, traveling around to meetings, in the outpatient department, on committees, and especially continuing his research and publishing. His income in those depression years and with all that non-practice activity did not rise that much, and in 1932 he returned to the regular faculty as an Associate Professor with more than 50 publications. (At least he got a promotion out of it.) The Decade of the Depression, the 1930s, was not only a time of desperation for many, but also a rather quiet time for medical research and progress. People were otherwise occupied. But Harrison was secure and happily occupied — preoccupied — with his research, teaching, and practice.

The next year, 1933, he was elect-

ed to membership in the "Old Turks," the AAP, then and now the top organization for academic internists and clinical research (plus a few pediatricians, neurologists, and other specialists).

Since he did not have enough to keep himself busy, he wrote a book, one destined to become highly influential for those times: *Failure of the Circulation*. It was a compilation and analysis of the foregoing work on congestive heart failure and circulatory shock, and it was masterfully done. Much of Tinsley's research of the 1930s was done not in animals, but in patients; and it attempted to develop physiological explanations for symptoms, such as shortness of breath, orthopnea, and the like, as well as physical signs of disease which would be obvious to the patient. For example, he had a system for quantifying dyspnea. He has a whole series of papers on the pathophysiology of symptoms in cardiac patients. In retrospect, this was perfect preparation for the innovations in the new Analysis of Symptoms section which were to form the beginning pages of the text *Principles of Internal Medicine* a decade later.

In 1939 he was elected President of the "Young Turks," and in 1940 he was given an honorary degree in medicine by the University of Michigan. The first edition of *Failure of the Circulation* had appeared in 1935 and had been a great success. The second edition, published in 1938, was more than an extensive revision; it was almost an entirely new book, with new organization and text.

Some of the events of the 1930s are listed in **Table 10**.

CHAIRMAN OF MEDICINE

Fig. 20 shows him around 1940 with his closest friend, Al Blalock, who was offered Chief of Surgery at Detroit's Henry Ford Hospital and turned it down, but used that offer to negotiate a full professorship at Vanderbilt — while Tinsley remained an associate professor. Academically, Tinsley was as far as he could go without becoming a chairman. In **Fig. 21** he is at that time of his life, ready for the chairmanship of a department of medicine.

In the late fall of 1940 he was contacted by Dr. C. C. Carpenter, Dean at the new medical school about to open in Winston-Salem, North Carolina. He accepted the job as Professor and Chairman of the Department of Medicine at the new school. Everyone knew that the tobacco and electric power man James B.Duke had given $10 million dollars in 1925 to establish Duke, with $4 million for the medical school, plus an amount in excess of $10 million for hospitals in the area, also mainly for Duke. These were enormous amounts of money in those days, worth many times such amounts in today's currency. Tinsley, Dean Carpenter, and others at Wake Forest (the parent university of Bowman Gray) assumed the other big tobacco fortune in North Carolina, that of Bowman Gray of the Reynolds Tobacco Company, would be comparable. So, in July 1941 the Harrisons moved to Winston-Salem. **Figure 22** is an aerial view of the North Carolina Baptist Hospital in 1941, site of the new medical school.

Try to imagine, then, the disappointment at the new school when they discovered that the Bowman Gray endowment was not $10 or $20 million dollars as they expected, but $600 thousand! Less than one million total!

On top of that, in December the

United States entered World War II, and everything became scarce. However, these were not the immediate reasons the Harrisons left 31 months later for Texas.

Tinsley always wanted his old friend Al Blalock, now Chief of Surgery at Hopkins, to visit Bowman Gray, and as late as February 1944 plans were being finalized for that visit in April of 1944. Then on March 2nd Tinsley telegraphed Blalock from Texas, "Write me in Dallas." What happened?

In the Carpenter Archives at Bowman Gray last year I found the minutes of an executive faculty meeting held in the Robert E. Lee Hotel of Winston-Salem on Thursday, January 6th, 1944. All 13 departmental chairmen plus the dean were there. But Tinsley was kept outside in an anteroom for most of the meeting, while the others complained about his interfering in their departments and harassing them for the low quality of their appointments. Finally, they invited him in. He immediately proposed a motion that all new recruits, and all faculty to be promoted from within, must be those who will make this the best medical school in the world. His nemesis, a carriage-trade doctor prominent in town, moved to table that motion. The motion carried 7 to 6. (Just the kind of faculty unity a dean loves to see!) Tinsley immediately jumped up, announced that he was resigning from the chairmanship, and in fact resigning from the faculty; and he started to leave the room. His friend "Moose" Morehead, Chief of Pathology, grabbed him and dragged him back to his chair. Tinsley apologized for losing his temper, but the damage was done — in fact, done before that. Six weeks later he was in Dallas, where he was their new (and first) Chief of Medicine and Dean of the Faculty of Medicine at the Southwestern Medical School just getting started.

His new situation at Southwestern, however, did not include magnificent new facilities. The office for the Department of Medicine is shown in **Figure 23**. It was a small ramshackle building, two rooms constructed of rather thin plywood, cracking under the weather as can be seen in the photo. The few other medical school buildings on the outskirts of Dallas were similarly constructed of emergency materials commandeered with the aid of the U.S. Army for the medical part of the war effort.

Southwestern Medical School was created by the Alabama physician Edward Carey, who was born at Chunnenuggee Ridge near Union Springs, Alabama, at nearly the same time Groce Harrison was born, studied ophthalmology in New York, moved to Dallas, became President of the American Medical Association, and started Southwestern when Baylor Medical School moved from Dallas to Houston in 1943, lured by millions of dollars from M.D. Anderson funds.

When Baylor moved to Houston, it left students and faculty in Dallas but because of the bitter fight refused them the use of the old buildings, still owned by Baylor. Carey used his recently created Southwestern Medical Foundation, plus aggressive fund raising and promises to the armed forces, to build emergency facilities to be used for the duration of the war. However, these emergency facilities were not replaced with more solid traditionally built structures until 1958 and later. Now in 1994 Southwestern is one of the world's leading medical schools,

just as Tinsley Harrison had hoped a half-century before, with four Nobel Laureates on the faculty and its residency positions in great demand. When the British scientific journal *Nature* published a review of "Research in Texas" several years ago, they reprinted a photograph of these ramshackle buildings. The fact that these buildings still constituted the physical structure of the Southwestern Medical School in 1958, less than 40 years ago, brings home how enormously fast the currents of history hurtle us along as we hardly notice the speed of the changes — future shock.

The plywood shacks, locally referred to as "henhouse classic," were the best the wartime shortages permitted. The "Anatomy Building" was similarly constructed of plywood, which rapidly cracked and peeled from weathering. T. Joseph Reeves, M.D., later a leading cardiologist and Chairman of Medicine at Alabama's UAB, was a medical student in the building that summer as a first year student. He recalls dissecting cadavers there in the sweltering heat of the Texas summer, with no air conditioning and poor ventilation from the malfunctioning windows, which would neither fully open nor fully shut, the stench of formalin and intestinal contents pervading the place so thoroughly that the faculty advised the students to smoke cigars to help the atmosphere. The plumbing was so unprotected that the pipes often froze in winters. At least they had heat back at Bowman Gray.

There were other problems. Two fires destroyed much of Tinsley's research notes and the material for a third edition of *Failure of the Circulation*. But the worst thing of all, in October 1944, was the loss of the eldest son, their firstborn and "apple of their eyes" on whom they had placed so much hope, and who had matured so perfectly. "Woody" was lost at sea in a navy plane. Neither Tinsley nor, especially, his wife Betty ever really recovered from this.

Despite these problems and the wartime privations, the work went on at Dallas, where Tinsley continued his relentless pursuit of "the best medical school in the world. " The war eventually ended, and Texas boomed. A grateful U.S. government passed the GI bill and legislation changing the nation's system for medical care of veterans from the civil service to "Title 38," which meant that the physicians, nurses, and dentists were removed from the stultifying effects of the civil service regulations. That legislation in 1946 also purposely led to the placing of new VA hospitals adjacent to medical schools and encouraged cooperation between the VA and the schools. The purpose of this was twofold. First, the new hospitals would provide facilities for residency training for the many physicians now being discharged from the service and desirous of specialty training, most of the specialty boards having been established in the 1930s. Second, the schools would be given the responsibility for staffing the VA Hospitals with top flight doctors rather than the eight-to-four-thirty grinds characteristic of the previous civil service era. Tinsley took full advantage of the VA at the nearby McKinney VA Hospital, where Ben Friedman, his first research fellow at Vanderbilt in 1931, was an internist on the VA staff. The VA provided important financial support for faculty, residents, and staff, as well as a good place for the clinical training of medical students. Parkland Hospital was also

important, but it was in many ways more independent than the VA and more difficult to deal with.

Figure 24 shows Tinsley in his office in the henhouse classic building. The little rectangle to his right just above the telephone was a door to the office of his secretary Miss Minnie Mae Timms — the simplest of all intercoms.

Tinsley was always popular with his students, whom he loved and who generally loved him in return, and **Figure 25** is a pretty good likeness of him by a medical student about 1948. He would walk back and forth and make engaging comments about the intricacies of the heart and its diseases, imitating various cardiac murmurs, snaps, squeaks, gallops, etc., by contortions of his mouth, tongue, and lungs, all to the great amusement and instruction of the students. It was said that "he could give a superb and captivating grand rounds on an old piece of shoe leather" and that no one had ever gone to sleep in one of his lectures. I do not recall, however, ever having seen him smoke while lecturing, despite his well known lifelong cigarette habit.

Tinsley Harrison always claimed, at least late in life, that he was emphatically not a cardiologist, but a general physician! But if you look at what he published and which organizations he was active in, he was a cardiologist — a generalist, too; but certainly a cardiologist.

Before 1948 the American Heart Association had been a quiet scientific society where members met to present papers to each other and publish a journal. That year, 1948, just after the war, the AHA changed the organization, made Tinsley Harrison president, and began to devote itself predominantly to raising money for cardiovascular research, both through private donations and by lobbying the federal government for support of research. For many years Harrison was editor of the cardiology section of *The Yearbook of Internal Medicine*. In 1948, partly through the efforts of Alabama's Senator Lister Hill,[k] the National Heart Institute was established, and Tinsley became a member of the first National Heart Institute Advisory Council.

Then, in the summer of 1945 with the stimulus of Dr. Morris Fishbein, who had recently retired as Editor of the Journal of the American Medical Association, Harrison began work on a new kind of textbook of medicine, one that emphasized the way the patient presents to the doctor, rather than the way the doctor studies diseases; and one that emphasized pathophysiology, especially the pathophysiology of symptoms. As always with Tinslev Harrison, it was the patient who was central and always of first consideration!

In the late 1940s he was working extremely hard as usual, but perhaps with the additional spur of some depression from the death of Woody. He began to experience personal and professional difficulties reminiscent of those that had hounded him at Bowman Gray, for him major problems. But he pressed on with writing and editing the new textbook of internal medicine as well as his multiple other duties. Others on the faculty and in the administration did not seem to want to push ahead as vigorously for high quality as he did, and again this discrepancy caused difficulties. This time help came from home. **Figure 27** shows the UAB area, looking west from the air, about 1950.

THE THIRD NEW SCHOOL

In Birmingham, in the winter and spring of 1950, Dr. Seale Harris, Senior, discoverer of hyperinsulism and founder of the Seale Harris Clinic, was having a series of lunches with Groce Harrison, Tinsley's father. Dr. Harris was the father of Tinsley's erstwhile friend and colleague at Vanderbilt, Seale Harris, Jr., and a good friend of Groce, now retired from active practice but still very much interested in medical affairs, as only appropriate for a former president of the state medical association.

Seale Harris, Sr., was also, in good medical tradition, a bitter rival of another prominent Birmingham physician, James S. McLester, who had been President of the American Medical Association and was a member of that influential academic organization of internists, the Association of American Physicians, or "Old Turks." That spring of 1950 it was obvious that the new medical school in Birmingham might soon be getting a "full-time"(l) regular chairman for the Department of Medicine to replace the system of having practicing physicians serve in such positions, McLester himself being Chief at that time.

Thus, in 1950 as Tinsley was having his troubles, Seale Harris, Sr. lunched with his friend Groce Harrison at Groce's house on Cliff Road, while a young medical student sat quietly at the table and listened — Buris R. Boshell, who was living there on Cliff Road taking care of the elderly Harrison couple. (m)

Now the last thing in the world Seale Harris wanted was for his rival McLester, or his rival's son James B. McLester, to become the regular "full-time" chairman of medicine at the new medical school. So the two plotters, Harris and Harrison, invited Dr. John M. Gallalee, President of the University of Alabama, to lunch with them, and there, with the young Boshell taking careful mental notes, they lobbied for Tinsley Harrison to be named chairman.

Fig. 28 is another photo from about 1950 of the area to become UAB, this time looking east. Not much compared to now, but a good deal better than the school in Dallas, which had another eight years to wait for better structures.

Thus, the machinations of the world steered the currents of history and brought Tinsley Harrison home, the same year his *Principles of Internal Medicine* first appeared. The book was a tremendous success, and he was too, especially with the students. The title page of that first edition has always seemed to me to reflect cultural changes in the United States, as it changed over subsequent editions. **Figure 29** we see the title page from the first edition. Note that it lists the five editors by name only, without even designating the M.D. degree. In **Figure 30**, by contrast, is the title page from the 13th edition. It lists not only the names, but also the degrees (including honorary degrees) and the named professorships held by the six editors. More informative, perhaps, but also reflective of our changes in medicine over the past half-century — perhaps more like old Europe and its royalty.

Once in Birmingham, Harrison began to fill his faculty and house staff with physicians trained elsewhere as well as locally. **Figure 31** shows this group in 1957.(n) It was to this stellar group that Dr. C. J. Watson brought his

wife in 1957, but really to see "The Chief," as he was now often called, Tinsley Harrison. Walter B. Frommeyer, the Cincinnati hematologist who followed Harrison as Chairman of Medicine and became President of the American Heart Association in 1964 (the same year the National Heart Institute changed into the National Heart and Blood Institute) is in front center. Howard Holley, right end of the front row, started the Division of Rheumatology and recruited Claude Bennett from Cal Teeh in 1965. And so on.

At this point, however, Harrison was weary and wary of administrative jobs, and in 1957, age 57, he resigned from the chairmanship of medicine. He continued as editor of the *Principles of Internal Medicine* through the first five editions, then he gave that up, too. Throughout the 1950s, '60s, and early '70s he continued to gather recognitions and honors, as well as grateful pupils. And he helped J. J. Kirschenfeld, M.D., establish in Montgomery the first residency program in the state outside the cities of Birmingham and Mobile. And the book thrived. **Table 12** lists some of the events of those times.

Harrison was very competitive, and he liked to throw barbs at the competitors. In **Fig. 32** he is in the 1960 medical school yearbook commenting on the main competing textbook of medicine in the 1950s, and even now, the *Cecil Textbook of Medicine*, which Harrison's PIM has largely replaced.**(o)**

He seemed to have entered a hypermature philosophical phase of life. For example, he declined the presidency of the Association of American Physicians ("Old Turks") in the mid-1960s, thereby moving George Thorn's presidency up a year. Despite this withdrawal from mueh of the national activities, he remained hyperactive and intense as ever at home. During the 1960s and early '70s Tinsley continued to make rounds with medical students and residents, attended conferences, criticized the course of medicine vigorously and openly, and collected many honors in cardiology and medicine generally. Some are listed in **Table 12**.

Fig. 33 shows an award he seemed to appreciate most, the Master Teacher Award from the American College of Cardiology, because he had deep convictions about teaching and commitment to medical students. The students themselves were close to his heart, perhaps in some ways closer than his own family. In 1974 I taped some conversations with him at his home. Listen to what he said.**(p)** (JAP is me, and TRH is Tinsley Harrison.)

JAP: You mentioned your father. He thought this Birmingham Medical College (1894-1915) was of poor quality, though it paid 6% annual dividends — now how can you knock that, six percent dividends? He wanted to abolish it because of quality education. How do you define quality medical education?

(Long pause)

TRH: The inculcation of character as a physician, above and beyond the concept of ordinary character in a citizen.

JAP: The inculcation of character as a physician

TRH: As a physician!

JAP: above and beyond the usual concept of character in a citizen.

TRH: Yes.

JAP: You put the whole thing on character, not whether or not he knows

more anatomy or physiology or that sort of thing?

TRH: No. I gave you my number one desideratum. My number two would be ..., but let me digress and say that character I define as dedication, obligation. responsibility to patients that far exceeds the responsibility to society that a fine business man feels.

JAP: You mean because the physician is obligated to the individual patient?

TRH: Also to society — both.

In 1968 he had a myocardial infarction, made careful notes of his own symptoms, and included his own case among those reported in a book on ischemic heart disease he was writing with Dr. T. Joseph Reeves, who became Chief of Medicine at Birmingham later that year.

Here he is in **Figure 34** at his cabin on Lake Martin, some 90 miles south of Birmingham. After his MI, he named this cabin "Coronary Seclusion," and in **Fig. 35** he is at Coronary Seclusion reading an electrocardiogram (which he always called EKGs) with fellow internists and cardiologists Joe Reeves and John Holt, both of whom remain in practice today.

Finally, in August 1978, he suffered his final illness -- a massive myocardial infarction, a disease essentially unknown to medicine 78 years earlier when he was born.

Dr. Cecil Coghlan, one of his former cardiology fellows, took care of him, but Harrison knew exactly what was going on and refused hospitalization. Dr. Coghlan seduced him into entering the hospital "just temporarily," as he said, so he could actually see the infarct on the new radionuclide scan. This he did. But he never put out any urine, and only a low blood pressure was maintained despite various i.v.drips. We would remove his oxygen so he could have his cigarettes, but he continued to complain that he wanted to go home to die; and we saw no reason not. So he did.

He is gone, but his legacy lives on in his pupils and his writings, but especially his spirit, which was one of total dedication to medicine.

Fig. 37, Sculptor Cordray Parker's statue of Tinsley Harrison stands at UAB on University Boulevard in front of the Tinsley Harrison Tower, built by the Department of Medicine under the leadership of Dr. Thomas N. James. Beside the statue are two pedestals bearing what are probably the two most famous paragraphs ever written by Harrison, the first and last paragraphs from the introduction in the first edition of the *Principles of Internal Medicine*, 1950. These were written by Tinsley Harrison personally:

"No greater opportunity, responsibility, or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering he needs technical skill, scientific knowledge, and human understanding. He who uses these with courage, with humility, and with wisdom will provide a unique service for his fellow man, and will build an enduring edifice of character within himself. The physician should ask of his destiny no more than this; he should be content with no less." (First paragraph)

"Tact, sympathy, and understanding are expected of the physician, for the patient is no mere collection of symptoms, signs, disordered functions, damaged organs, and disturbed emotions. He is human, fearful, and hopeful, seeking relief, help,

Fig.36, his gravestone.

and reassurance. To the physician, as to the anthropologist, nothing human is strange or repulsive. The misanthrope may become a smart diagnostician of organic disease, but he can scarcely hope to succeed as a physician. The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people."

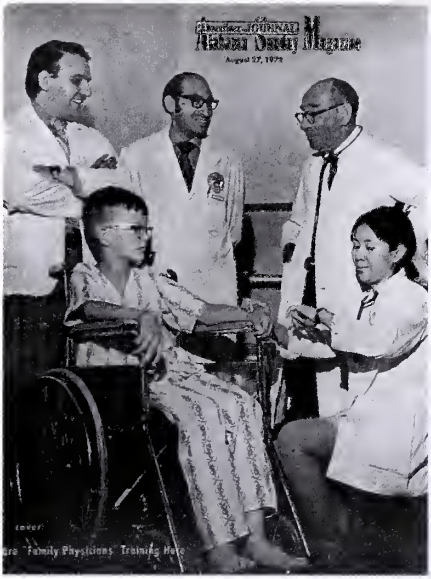


Fig. 2 shows him again as most of us remember him, again with a patient and students, this time in Montgomery in 1972. He always started with a patient, especially at Medical Grand Rounds. In those days this was almost always a live patient in a conference room or lecture hall with the students and physicians. You may recognize some of the young doctors — Crawford Owen is one — but the patient was central. The patient was first. The students of medicine were second. And his research followed naturally from these.

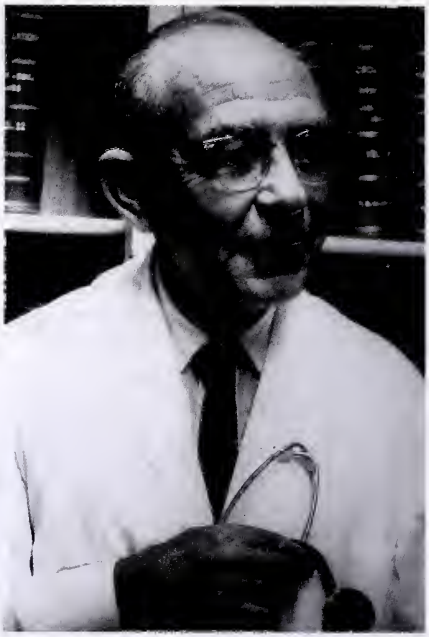
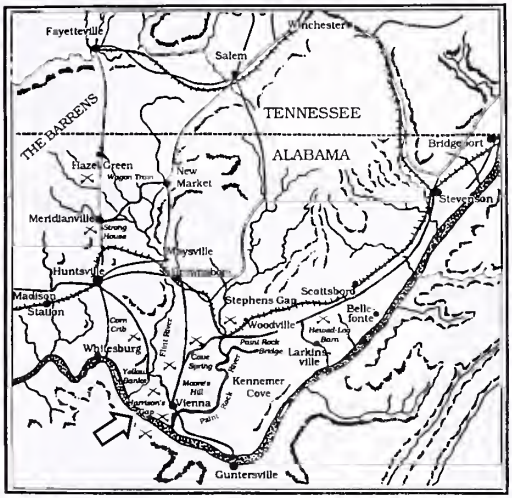


Fig. 3 Tinsley Harrison around age 55 - mid-century for both him and the twentieth century.

Fig. 4 the grave of the first of the Harrison physicians to practice in Alabama, showing the headstone of John Tinsley Harrison, Senior, M.D.

The grave is in this graveyard (Fig. 5) about a mile-and-a-half west of the village of New Hope in Madison County, near Huntsville, in north Alabama near the Tennessee line. He was born in 1799, and his wife was born in 1796, when George Washington was president.



MAP OF JOHNSTON'S "NEW CONFEDERACY"

SKIRMISHES

Harrison's Gap	April 21, 1864
Hollowell's Landing	May 12, 1864
Corn Crib	June 27, 1864
Yellow Bank Creek	July 8, 1864
Moore's Hill	August 11, 1864
Cave Spring	ca. October 1864
Meridianville	November 26, 1864
Hewed-Log Barn	ca. December 1864
Paint Rock Bridge	December 31, 1864
Hazel Green	January 18, 1865

Fig 6. The location of the farm was at a place called "Harrison's Gap" (arrow).

Fig. 8 Finally, after some weeks or months, J. T. Harrison, Jr., M.D., ended up as a guest in the house shown here. The house was built in the early 1830s by Jared E. Groce, who operated a country store at the nearby crossroads.

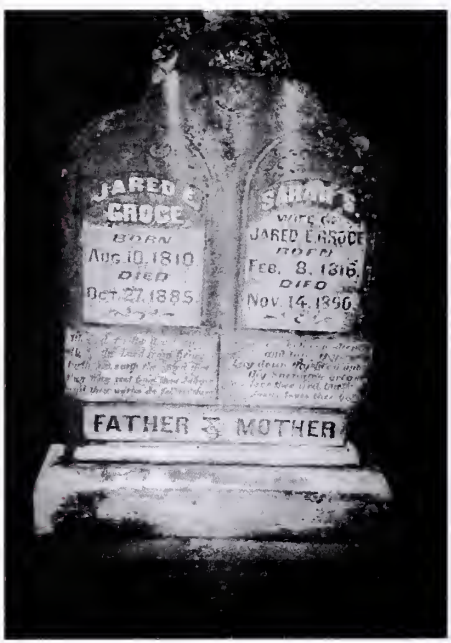


Fig. 9 Behind the house is a small family graveyard containing about 20 graves, where the worldly remains of these members of the Groce family still reside. Here is the headstone for the graves of Jared and Sarah Groce, Tinsley R. Harrison's great grandmother and grandfather.

Groce moved to Baltimore to obtain a second medical degree from the Medical College of Baltimore in 1892-93. Fig. 10, Groce as a young man in Baltimore at that time.

Fig. 11 shows a photo of the young couple participating in another wedding around the time of their own marriage. Groce and Louisa (whom the family always called "Lula") are on the extreme right looking fondly at each other. This wedding was that of Lula's sister Emily. Thomas J. Jackson, an uncle of these two sisters and long dead at the time of this photo, was better known as "Stonewall" Jackson of Civil War fame. He had been a groomsman in the wedding of their parents, the Bondurants.

Fig. 12 Tinsley was born in this house in Talladega on March 18th, 1900. Groce had bought the house shortly after his marriage. It is now occupied by the man who was recently mayor of Talladega. When Groce bought it just before 1900, it was very modern.

The photo, Fig. 13, was taken on April 20, 1910, the 76th birthday of J.T. Harrison, Jr., Tinsley's grandfather. It was a family gathering on the porch of the old Dr. J.T. Harrison farm near Munford, east of Talladega. On the left at the head of the table is the patriarch, J.T. Harrison, with his wife Sarah at the other end of the long table, the extreme right in this photo. Dr. Groce Harrison is the older man on the other side of the table facing us, and to his right is the young ten-year-old Tinsley in the dark suit with his younger (but larger) brother W.G. Harrison, Jr., in the white shirt seated between him and his father. There are three generations of Alabama physicians in this one photo, all in the same family.

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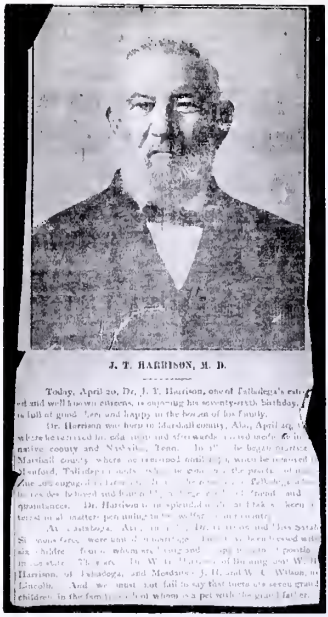


J. T. HARRISON, M. D.

Today, April 20, Dr. J. T. Harrison, one of Talladega's esteemed and well known citizens, is enjoying his seventy-ninth birthday, in full of good cheer and happy in the bosom of his family.

Dr. Harrison was born in Marshall county, Ala., April 20, [illegible] where he received his [illegible] and afterwards [illegible] native county and Nashville, Tenn. [illegible] Marshall county where he remained until [illegible] Stanford, Talladega county, where he [illegible] [illegible] and engaged in [illegible] [illegible] [illegible]

Fig. 16, with some of his classmates as he graduated.

Fig. 17, the Vanderbilt Medical School around the time Harrison and Blalock arrived "the same day in 1925."

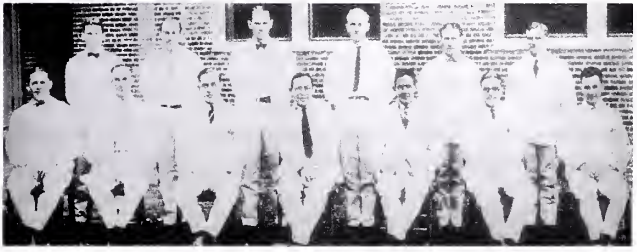


Fig. 18, the original Vanderbilt house staff in 1925, with Tinsley in the center of the front row and Blalock to his left (our right).

Fig. 19, about that same time with some faculty colleagues. He is third from right on the front row.

Fig. 20, 1940 with his closest friend, Al Blalock, who was offered Chief of Surgery at Detroit's Henry Ford Hospital and turned it down, but used that offer to negotiate a full professorship at Vanderbilt — while Tinsley remained an associate professor. Academically, Tinsley was as far as he could go without becoming a chairman.

Fig.21, at that time of his life, ready for the chairmanship of a department of medicine.

Fig. 22, is an aerial view of the North Carolina Baptist Hospital in 1941, site of the new medical school.

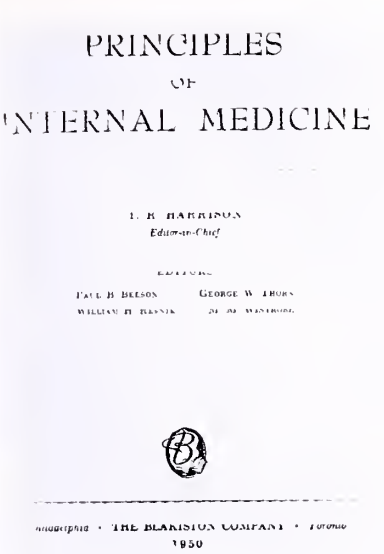
Fig. 23, the office for the Department of Medicine. It was a small ramshackle building, two rooms constructed of rather thin plywood, cracking under the weather as can be seen in the photo.

Fig. 24, Tinsley in his office in the henhouse classic building. The little rectangle to his right just above the telephone was a door to the office of his secretary Miss Minnie Mae Timms — the simplest of all intercoms.

Fig. 25, a pretty good likeness of him by a medical student about 1948.

Fig. 27, the UAB area, looking west from the air, about 1950.

Fig. 28, another photo from about 1950 of the area to become UAB, this time looking east. Not much compared to now, but a good deal better than the school in Dallas, which had another 8 years to wait for better structures.



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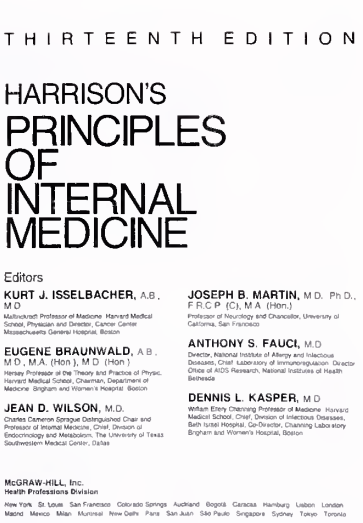

THIRTEENTH EDITION

HARRISON'S
PRINCIPLES
OF
INTERNAL
MEDICINE

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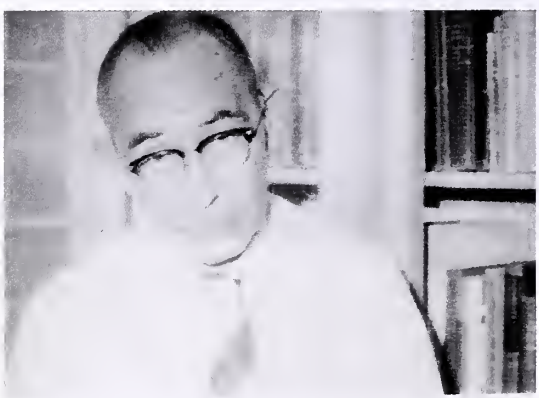
Fig. 29, the title page from the first edition. Note that it lists the five editors by name only, without even designating the M.D. degree. Fig. 30, by contrast, is the title page from the thirteenth edition. It lists not only the names, but also the degrees (including honorary degrees) and the named professorships held by the six editors. More informative, perhaps, but also reflective of our changes in medicine over the past half-century — perhaps more like old Europe and its royalty.

Fig. 31, it was to this stellar group that Dr. C. J. Watson brought his wife in 1957, but really to see "The Chief," as he was now often called, Tinsley Harrison. Walter B. Frommeyer, the Cincinnati hematologist who followed Harrison as Chairman of Medicine and became President of the American Heart Association in 1964 (the same year the National Heart Institute changed into the National Heart and Blood Institute) is in front center. Howard Holley, right end of the front row, started the Division of Rheumatology and recruited Claude Bennett from Cal Tech in 1965. And so on.



"Cecil and Loeb! Oh, I always throw those pamphlets away."

Fig.32, Tinsley in the 1960 medical school yearbook commenting on the main competing textbook of medicine in the 1950s, and even now, the Cecil Textbook of Medicine, which Harrison's PIM has largely replaced.

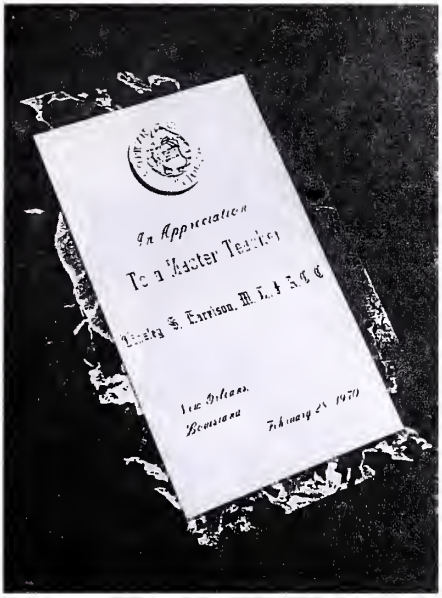


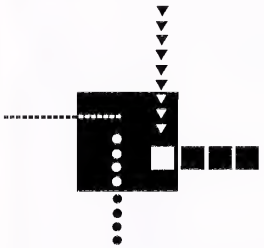
Fig. 33, an award he seemed to appreciate most, the Master Teacher Award from the American College of Cardiology, because he had deep convictions about teaching and commitment to medical students.

Fig.34, in at his cabin on Lake Martin, some 90 miles south of Birmingham. After his MI, he named this cabin "Coronary Seclusion."

In Fig.35 he is at Coronary Seclusion reading an electrocardiogram (which he always called EKGs) with fellow internists and cardiologists Joe Reeves and John Holt, both of whom remain in practice today.

Fig. 37, Sculptor Cordray Parker's statue of Tinsley Harrison at UAB on University Boulevard in front of the Tinsley Harrison Tower, built by the Department of Medicine under the leadership of Dr. Thomas N. James.

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

December 4-8, 1997
Wyndham Anatole Hotel
Dallas, Texas

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- **Joint Commission's ORYX initiative**
- **CPT coding changes and self audits**
- **Measuring and managing outcomes**
- **Group dynamics and team building**
- **Fraud and abuse compliance**
- **Advocating your issues at home**
- **New legislation and AMA action**
- **Medical staff reengineering and bylaws**
- **Forming a physician organization**
- **Patient involvement in medical decision-making**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- Attend practical education programs to improve your medical practice, earn **10.5** hours of CME credit ** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1997 Interim AMA-OMSS Assembly Meeting on December 4-8, 1997, at the Wyndham Anatole Hotel in Dallas, Texas. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 10.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America

TINSLEY HARRISON & INTERNAL MEDICINE

1) SERVICE - TRH claimed this as his first priority & best accomplishment

2) TEACHING - TRH most famous for this; without peer

- individual students/physicians at bedside/office
- groups: unexcelled lecturer & bedside teacher
- Books:

PIM, Principles of Internal Medicine - 1950 & after

Failure of the Circulation - 1935, 1938

Ischemic Heart Disease - 1968

Your Future Health Care - 1974

3) RESEARCH - More than 200 papers & chapters - 1924-1977

President of ASCI - 1939

Kober Medal of AAP - 1968

Many honors & societies, honorary degrees, etc.

4) ADMINISTRATION -

First Chief Medical Resident - Vanderbilt 1925

First Chairman of Medicine - Bowman Gray 1941

First Chairman of Medicine - Southwestern 1944

First Chairman of Medicine - UAB 1950

Table 1

MEDICINE IN THE 17th & 18th CENTURIES

1562	Witchcraft made capital offense in England
1590	Hans & Z. Jannsen invent compound microscope
1610	Van Helmont: respiration/combustion; "gas"
1628	William Harvey's De Motu Cordis
1661	Robert Boyle defines chem. elements; acetone
1663	1st hospital in American colonies (Long Island)
1665	Hook coins term "cell" in Micrographia
1673-77	Leeuwenhoek makes microscopes, finds protozoa
1675	Thomas Sydenham; founds scientific nosology; anticipates & inspires Sauvages & Linnaeus
1692	Salem witch trials in America
1708	Hermann Boerhaave (Leyden): Elementa Chemiae; uses Fahrenheit thermometer in clinic
1731	Sauvages: Traite des Classes des Maladies
1735	Linnaeus: Systema Naturae; binomial system
1761	Morgagni: Seats and Causes of Disease Auenbrugger: Inventum Novum (percussion)
1763	Linnaeus: Genera Morborum; early nosology
1765	James Watt invents steam engine
1792	Galvani's essay on animal electricity Voltaic pile (battery) Eli Whitney's cotton gin
1796	Edward Jenner vaccinates Wm Phipps
	Melinda Harrison born in Virginia, United States. (G. Washington, President)
1799	J.T.Harrison, Sr., born in Virginia.
	JOHN TINSLEY HARRISON, Sr., M.D.
	our TINSLEY HARRISON'S GREAT GRANDFATHER,
	WAS BORN AT THE BEGINNING OF THE 19TH CENTURY
	just as
	TINSLEY R. HARRISON, M.D.,
	WAS BORN AT THE BEGINNING OF THE 20TH CENTURY

Table 2

NOSOLOGY
(NOSOGRAPHY)

Nosology "A classification or arrangement of diseases." (OED)
"The branch of medicine dealing with classification of diseases." (Webster).

Nosography "A (or the) systematic description of diseases" (OED)
(from nos = "disease" + ology = "study of")

(e.g.: nosocomial - from nosokomeion = "hospital": associated with or taking place in a hospital).

1971	BAILEY: Nosology: A Treatise Concerning Diseases	
1977-84	CULLEN: *First Lines Physic*: "To establish a Methodical Nosology, or an arrangement of diseases according to their genera and species."	
1799	*Med. Jrnl. I. 42*: "There is little hope of seeing a theory of medicine, or a System of Nosology established, which .. will .. stand the test of ages."	
1799	Med. Jrnl. I. 42: "There is little hope of seeing a theory of medicine, or a System of Nosology established, which .. will .. stand the test of ages."	
1818	HOSACK:	A system of Practical Nosology, to which is Prefixed a Synopsis of the Systems of Sauvages, Linnaeus, Vogel, Sagar, MacBride, Cullen, Darwin, Crichton, Pinel, Parr, Swediaur, and Young, With Reference to the Best Authors on Each Disease.
1827	*Lancet 252*/2: "Nosology is of course frequently taught without therapeutics."	
1876	*Trans.Clinical Soc. IX*.91. "...the divided state of the nosology of leuchaemia."	
1919	FABER:	*Nosography. The Evolution of Clinical Medicine in Modern Times*. (Paul B. Hoeber, Inc.)

Table 3

MEDICINE IN TIME OF J.T.HARRISON Senior & Junior
(1799-1875) (1834-1915)

1819	Laennec: On Mediate Auscultation (stethoscope)
1824	(Wm. Harrison born in Alabama, older son of JTH, Sr)
1829	Daguerre - invents photography
1834	(J.T.H., Jr., born in Alabama (H.s Gap), TRH's grandfather)
1839	Josef Skoda: Treatise on Percussion & Ausc.
1840	Half Ala. M.D.s = Thomsonians (uneducated herbalists)
1844	Ala.'s 1st med. school: Thomsonian, in Wetumpka
1846	Ether anesthesia - Wm.T.G. Morton & J.C.Warren, Boston
1847	American Medical Association founded
1851	Leared: invents binaural flexible stethoscope
1851	Ala.'s 2nd med. sch.: Graefenberg, in Dadeville
1855	(J.T.H., Jr. earns M.D. @ U. of Nashville Med. Sch.)
1859	Charles Darwin publishes Origin of Species
	1861-65 - CIVIL WAR

Table 4

MEDICINE IN TIME OF J.T.HARRISON, Jr., (1834-1915)
1861-65 - CIVIL WAR

----------Louis Pasteur (1822-95), founder of bacteriology
1848: molecular dyssymetry
1857: fermentation
1862: spontaneous generation
1863: diseases of wine
1865: " " silkworms
1871: microorganisms in beer
1869-71 - Mendeleyev formulates Periodic Law
1871 - Wm. Groce Harrison born to J.T., Jr. & Sarah, Munford, AL
(1875 - J.T.Harrison, Sr., dies)
1877: anthrax, chicken cholera (Pasteur)
1880: preventive vaccinations (Pasteur)

----------Robert Koch (1843-1910), founder of bacteriology
1876: life history & spores of anthrax
1881: agar plates for pure cultures steam sterilization
1883: discovers TB bacillus
Koch's postulates in same paper
Discovers cholera vibrio in Egypt
1905: Nobel Prize
1895 Roentgen discovers x-rays; 1st Nobel Prize Ph.
1896 Becquerel discovers radioactivity
1896 (Wm. Groce Harrison marries Louisa Marcia Bondurant of Va.)
1897 J.J. Thompson discovers the electron
1900 TINSLEY RANDOLPH HARRISON, born in Talladega, AL, March 18.
1901 Nobel Prize Awards begin

Table 5

T.R. HARRISON & Development of Medicine - 1900-1978

1900 -	TINSLEY RANDOLPH HARRISON born 18 March, Talladega, AL	
1901	Emil von Behring wins 1st Nobel Pr. for Med. or Physiol. for serum therapy vs. diphtheria	
1902-3	Einthoven improves string galvanometer & makes 1st practical EKG	
1904		Groce Harrison offered Chief of Medicine at Med. College of Ala., Mobile
1905	Korotkoff invents use of sounds @ brachial art. to det. BP with Riva-Rocci (1896) cuff	
1906	Radium hospital opens, Paris, France	TRH moves to Birmingham
1908	Ehrlich & Metchnikoff win Nobel in Med., immunity	
1909-10	1st EKG in U.S. (G. Bond, Hopkins-or-A.E. Cohn, N.Y.)	
1910	Sickle-Cell Disease described by James B. Herrick	
1912	Myocardial infarction described by James B. Herrick, JAMA	
1915-6		TRH - Marion Military Ins.,BS
1916-7		TRH - U. Michigan - soph. year
	(1917-18 - U.S. participates in WORLD WAR I)	
1917-18		TRH - U. Mich. - Junior "
1918-19		" " " Sr.yr/1st yr med sch
1919-20		Hopkins - 2nd yr med school
1922 -		M.D. from Hopkins

Table 6

ORGANIZATIONS IMPORTANT FOR INTERNISTS
ACADEMIC ORGANIZATIONS

Name	Date Founded	Publications
American Federation for Clinical Research* (AFCR)	1940	*Clinical Research.* (quarterly)
American Society for Clinical Investigation* (ASCI, or "Young Turks")	1909	*JCI* (monthly)
Association of American Physicians* (AAP, or "Old Turks")	1886	*Transactions.* (annually)
Federation of American Societies for Experimental Biology (FASEB, or "the Federation")	1912	*FASEB JOURNAL* (14 x year)

MEETINGS:

Tri-Society: ~1 May annually (3 days+) * for CLINICAL research ("Clinical" = any tissue >homogenate)

FASEB: ~15 April annually (5 days) ("Experimental Biol.-94")

++ Hundreds of Specialty Societies

Table 7

ORGANIZATIONS IMPORTANT FOR INTERNISTS
CLINICAL PRACTICE

Organization	Founded	Publications
American College of Physicians (ACP)	1915	Annals IM ACP Journal Club Int. Observer
American Society for Internal Medicine (ASIM)	1956	Internist Int. Intercom
American Medical Association (AMA)	1847	JAMA Am. Med. News 10 Specialty journals + numerous pamphlets, bks., etc.
Medical Association of the State of Alabama (MASA) (reorganized (re-reorganized	1847 1868) 1873)	Ala. Medicine Ala. M.D.

County Medical Society & other Local Societies (e.g., Birmingham Society of Internists, Birmingham Academy of Medicine, Birmingham Clinical Club, Southern Medical Association, etc.)

++ Hundreds of Specialty Societies

Table 8

T.R. HARRISON & Development of Medicine -1900-1978

1922-24		Intern.-Res., Brigham Hospital
1924		Becomes memb Am. Coll. Physic.
1924-25		Sr. Assist. Res., Hopkins
1925-26		1st Chief Med. Res., Vanderb.
1925-27		Instructor in Med., Vanderblt.
1927		Becomes member AMA
1927-28		Year in Europe-Rockefeller Fel
1927	Cecil Textbook of Medicine, 1st edit.- Saunders	
1928	Fleming - Penicillin (not produced in useful quantities until 1943)	TRH returns from Europe; appointed Assist. Prof. Elected memb. Am.Soc.Cl.Inv. ("Young Turks")

(1930-40 -- Economic Depression in U.S.)

Table 9

T.R. HARRISON & Development of Medicine - 1900-1978

(1930-40 -- Economic Depression in U.S.)

1931-33		Private Pract.; Clin. Faculty
1932-35	Prontosil (sulfonanilamide) disc. by Domagk & French chemists	
1933 -		Associate Prof. Medicine, Vand Elected Association Amer. Phys ("Old Turks")
1934		TRH's 1st Fellow: Ben Friedman
1935		Failure of the Circulation,Ed1
1936		Becomes member Am. Heart Assn.
1937		ABIM-grandfathered Board, Med.
1938		Failure of the Circulation,Ed2
1939	Electron microscope	President, ASCI
1940		Honorary M.D. (Univ. Michigan)
1941		Becomes 1st Prof. & Chm. Med., Bowman Gray Sch. of Medicine

(1941-45 -- U.S. participates in WORLD WAR II)

Table 10

T.R. HARRISON & Development of Medicine- 1900-1978

(1941-45 - U.S. participates in WORLD WAR II)

1943	Penicillin becomes available in limited quantities	
1944		Becomes 1st Chm. Med. & Dean at Southwestern Med. Sch., TX
1944	Streptomycin - Waksman	
1946		Founds SSCI (South. Soc. for Clinical Investigation) Starts work on PIM
1948	Cortisone synthesized (L. Sarrett)	President, Am. Heart Assoc. NHI estab. Becomes member 1st Council, Nat. Heart Inst, NIH
1950		Becomes 1st Chm. Med. & Dean Med. College of Ala., B'ham

Table 11

T.R. HARRISON & Development of Medicine - 1900-1978

1950	--------PRINCIPLES OF INTERNAL MEDICINE published----- PIM	
1951		Retires from Deanship; retains Chief of Medicine
1952	Martin & Synge - Nobel Prize for partition chromatography (Mikhail Tsvet published book re. chromatog. in 1910)	
1953	Watson/Crick - DNA	
1954	(Brown v Board of Education)	
1954	PIM, 2nd edition	
1955	(Autherine Lucy attempts to enter U. Ala.) ("Montgomery Bus Boycott - Martin Luther King)	
1957		Retires as Chief of Med; remains Prof.of Med. New Chairman (Frommeyer) creates "divisions;" names TRH Chief of Cardiology
1958	Tinsley Harrison national reception, AAP Mtg, Atlantic City	
1958	PIM, 3rd edition	
1958	Tinsley Harrison Lectureship Established at UAB	
1962	PIM, 4th edition	
1963	(Bombing of 16th St. church, Birmingham)	
1964	(U.S. Civil Rights Act)	
1965	(Selma-Montgomery March)	
1965		Relinquishes Chief of Cardiol. Becomes 1st Disting. Prof.,UAB

Table 12

Footnotes

b. Chinese, French, German, Greek, Italian, Japanese, Polish, Portuguese, Spanish, and English. The list of languages in which Harrison's Principles of Internal Medicine is available, as published on the back of the title page of the 13th edition, omits Polish, Turkish and perhaps others. A Polish edition is in the Harrison Room at the Reynolds Historical Library at UAB.

c. At the time of this presentation in 1994, Dr. William E. Dismukes, who was presiding over the Grand Rounds, correctly stated the meaning of the term, apparently the only faculty member at UAB other than the professional historians who knew.

d. Diagnosis Related Groups, a system frequently used to establish hospital payments for illnesses.

e. The medical curriculum in 1854-5, the years J.T. Harrison, Jr., attended, consisted of a course between 30 October and 31 March, or about 4 to 5 months. The student was also assigned a preceptor then, and the preceptor for J.T.H. was a Dr. Sowell. The school was large, even by today's standards, 220 students (22 from Alabama, 29 from Georgia, 3 Arkansas, 10 Kentucky, 1 Louisiana, 6 Mississippi, 2 Missouri, 1 North Carolina, 4 Texas, and 142 Tennessee). This information is from Ms. Mary Teloh, Director of the Historical Collection at the Eskind Biomedical Library, Nashville, TN. Ms. Teloh was also most helpful in locating records, photographs, books, etc., of Tinsley Harrison's years at Vanderbilt. No curriculum for 1891-2 was found, but it appears to have been not much different from that of 1854 despite the advances in Europe.

f. This photo was probably taken in 1895 or '96 at the Morrison-Bondurant plantation in Virginia, "Variety Shade." It is still owned by the descendants of the family as "The Variety Shade Landowners Association," and income from the timber is used to defray the costs of biennial family reunions.

g. Examination of old records at the archives of Harvard University, the Widener Library and the University of Michigan confirm these two claims; namely, that cotton prices tumbled in 1915 and that the tuition at Michigan was much less than at Harvard. No records could be found, however, to confirm Tinsley's acceptance-but-non-matriculation at Harvard, since the institution does not retain such records.

h. The term "originator" here would be disputed by some. Dr. Helen Taussig, the pediatric cardiologist at Hopkins, apparently had the idea of implanting the left subclavian artery end-to-side in the pulmonary artery in these patients to improve oxygenation of the peripheral blood. She attempted to convince Robert Gross, M.D., of Harvard to try the operation, but his response was, in essence, "Are you crazy? I've just received lots of positive recognition for tying off those shunts!" That is, he initiated the surgical closing of a persistent patent ductus arteriosus in children. Only then did the competitive Taussig approach Blalock, whose technical expertise with such a procedure was gained by working with Harrison at Vanderbilt in the 1930s creating experimental pulmonary hypertension in dogs.

i. This episode is recounted in further detail by Dr. William Longmire in his biography of Alfred Blalock.

j. Robinson was also closely connected with Hopkins and came to know Tinsley there while serving as Acting Chief of Medicine in 1923-25. It was Canby Robinson who laid out the grandiose plans for Vanderbilt, funded mainly by Rockefeller money, then moved to New York where he designed the New York Medical Center for Cornell.

k . Lister Hill was a lawyer immersed in a family of physicians and named after the inventor of antisepsis, Joseph Lister of Scotland, with whom his father had studied. He was the key player, along with Congressman John Fogarty of Rhode Island and Dr. James Shannon, then NIH Director, in building the modern NIH (National Institutes of Health at Bethesda, Maryland, just outside Washington). Senator Hill held a combination of positions unique in the history of the United States Senate: he was chairman of the committee responsible for authorizing a health bill; then he was also chairman of the committee for appropriations of money to carry out that authorization. These two functions, authorizing and appropriating, have traditionally been separated, and it is unlikely that any other individual will again have that much power, especially over health programs.

l. Dr. William L. Hawley, another prominent Birmingham internist, claimed that academic definitions for "full-time," etc., were as follows: The "full-time" faculty are gone away on academic trips all the time; the "part-time" faculty are away part of the time; and the unpaid "voluntary faculty" do

the work. There is considerable truth in this, and a better term than "full-time" would be "regular faculty," or, as some European schools term it, "ordinarius," as opposed to "extraordinarius."

m. The late B.R. Boshell transferred to Harvard Medical School the following year, took his house staff training at the Brigham Hospital, where he became Chief Medical Resident for two successive years, then returned to Birmingham, where he became Chief of Endocrinology and built the Boshell Diabetes Building at UAB before retiring and starting another diabetes center at Medical Center East in Jefferson County, Alabama.

n. Front row from the left are Thomas F. Paine, William H. Riser, Tinsley Harrison, James Strachan, Walter B. Frommeyer, Jr. (Chief of Medicine following Harrison), James A. Pittman, Jr., S. Richardson Hill, Jr., and Howard L. Holley. The group also includes William J. Hammack, William B. Jones, James C. Barrett, Sidney Chenault, John Todd, Omer Baker, Earle Shugerman, Rucker Staggers, Cecil Coghlan, L.T. Sheffield, and others.

o. Russell L. Cecil, M.D., originator and editor of the Cecil Textbook of Medicine in 1927, was born in Kentucky but lived in Alabama during his childhood. Besides being the main text competing with Harrison's PIM, Cecil has another connection with Alabama: The current coeditor-in-chief is Dr. J. Claude Bennett, President of UAB at the time of this presentation (1994) and formerly Chief of Medicine at UAB, now retired.

p. The tape was played at Medical Grand Rounds in 1994.

Credits for Figures

Fig. 1- UAB McCallum Arehives (TRH + patient + students)
2- UAB McCallum Archives &; *Montgomery Advertiser* (TRH, studs)
3- UAB McCallum Archives (TRH age 55)
4- John B. Harrison, M.D., D.M.D. & UAB McCallum Archives (JTH Sr. grave)
5- John B. Harrison, M.D., D.M.D. & UAB McCallum Archives (graveyard)
6- Charles S. Rice, *The Sword of Bushwhacker Johnston*, 1992 (map)
7- International Classification of Diseases, 9th Revision, Clinical Modification, 4th edition
8- UAB McCallum Archives (Groce house)
9- UAB McCallum Archives (Groce headstone)
10- John B. Harrison, M.D., D.M.D. & UAB McCallum Archives (Groce Harrison as a young man)
11- John B. Harrison, M.D.), D.M.D. & UAB McCallum Archives (wedding)
12- UAB McCallum Archives (Groce Harrison house in Talladega)
13- John B. Harrison, M.D., D.M.D. & UAB McCallum Archives (JTHarrison gathering around table at his 76th birthday party)
14- John B. Harrison, M.D., D.M.D. & UAB McCallum Archives (old JTH)
15- Bentley Historical Library, Univ. of Michigan, Ann Arbor (navy uniforms)
16- Alan M. Chesney Archives' Johns Hopkins (med. school graduates, 1922)
17- Vanderbilt Special Collections & Medical Archives (view of old Vanderbilt med. school)
18- Vanderbilt Special Collections & Medical Arehives (Vand. House staff, 1925)
19- Vanderbilt Special Collections & Medical Archives (TRH & faculty)
20- Vanderbilt Special Collections & Medical Archives (TRH, Blalock, & beer)
21- John B. Harrison, M.D., D.M.D. & UAB McCallum Archives (TRH's movie star pose)
22- Dorothy Carpenter Medical Archives, Bowman Gray Sch. of Med. (Aerial view of Bowman Gray)
23- Medical Archives, UTDallas Southwestern Medical Sehool (old Dept. Med. Office at Dallas)
24- Medieal Arehives, UTDallas Southwestern Medical School (TRH in Dallas office)
25.- UAB McCallum Archives (student sketch of TRH)
26- UAB McCallum Archives (NIH Advisory Council with TRH)
27- UAB McCallum Archives (aerial view of UAB area looking West)
28- UAB McCallum Archives (aerial view of UAB area looking East)
29- Blakiston Book Co. (Title p. of 1st edition)
30- McGraw-Hill Book Co. (Title p. of 13th ed.)
31- UAB McCallum Arehives (UAB int. med. house staff, 1957)
32- UAB McCallum Archives (Harrison commenting on Cecil, inel. Legend, "Cecil? Oh, I always throw those pamphlets away.")
33- UAB McCallum Arehives (ACC Master Teacher Award)
34- UAB McCallum Archives (TRH with sign "Coronary Seclusion")
35- UAB McCallum Archives (TRH in hammock reading EKG)
36- UAB McCallum Archives (gravestone of TRH)
37- UAB McCallum Archives (statue of TRH)

Practice Guidelines: Background and Access

Judy Burnham, MLS*

Practice guidelines, as defined by the National Library of Medicine are:

"a set of directions or principles to assist the health care practitioner with patient care decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances. They can provide a foundation for assessing and evaluating the quality and effectiveness of health care in terms of measuring improved health, reduction of variation in services or procedures performed and reduction of variation in outcomes of health care delivered."[1]

Practice guidelines can improve the quality of health care by reviewing the literature and current evidence for a medical condition. However, the quality of care can be lessened if the guidelines are not supported by sound scientific evidence. To be useful the guidelines must provide "practical unambiguous advice about specific health problems." They can help physicians with clinical decision making and help evaluate physician practices.[2] Time is an important factor for many physicians today and the use of practice guidelines can help the physician stay current on treatment.

The growth in the number of practice guidelines has been precipitated by differences in health care provision, the desire for cost containment and improvement of health care and a method of clinical audit.[3] Also, some fear that the increasing limitations on resources will effect the quality of health care delivered.[4]

In some instances, physicians can risk loss of reimbursement for services if specified guidelines are not followed. The question of medical malpractice comes to play also, as physicians are hesitant to either follow or ignore the guidelines because they fear either path will increase liability.[5] Some physicians view practice guidelines as "cookbook medicine" or a challenge to physician autonomy. Others see them as educational tools and good sources of advice.[6] Problems also arise when more than one guideline exist for a particular clinical condition.[7] Some regard guidelines as unrealistic, and feel they do not consider the realities of day-to-day practices.

There are several types of practice guidelines, depending on the method of development. Expert-based guidelines are developed by consensus of specialists in that discipline. Evidence-based guidelines are based on scientific evidence. Explicit guidelines use scientific evidence, along with analytic methods.[9] With the synthetic method, a guideline is developed by a specialist and a general practioneer

**University of South Alabama, Biomedical Library, for the Alabama Health Library Association.*

working together and is often used for development of local clinical guidelines. Health economies is often a method of guidelines development.[10] Guidelines may be either prescriptive or proscriptive.[11]

Practice guidelines are being developed by medical speciality societies, governmental agencies, insurers, hospitals, state governments and other health care organizations. The guidelines contain the agency's official statement concerning the prevention, diagnosis and/or treatment for specific medical conditions. They are usually developed by a team of experts with development taking up to three years and involving large sums of money, sometimes up to $1 million.[12] Although practice guidelines have been issued since the 1930s, the increasing cost of health care sinee the 1980s has increased their creation. Practice guidelines may be issued as journal articles, in books or as separate publications that are distributed by organizations. Those involved in the development of practice guidelines include the National Institutes of Health, the Centers for Disease Control and Prevention and private research organizations.

Practice guidelines should not be followed without questioning the methodology used in development. Guidelines that are not based on sound scientific evidence can lessen the quality of care. Lohr[13] notes that practice guidelines must be based on "rigorous science-based procedures," but involve both clinicians and patients, must focus on specific clinical circumstances and should be practical, explicit working documents. In an article in *American Family Physician*, Woolf[5] developed a set of 10 questions to ask when evaluating a practice guideline, including who wrote it, methodology used, and use of peer review. Basinski[14] lists steps in evaluating clinical practice guidelines including goals of guideline and evaluation, design, measurement and analysis.

Several articles have been written on the selection of topics and the development of practice guidelines.[5, 4, 10,16] The Institute of Medicine lists nine desirable attributes of clinical guidelines: validity, reproducibility, reliability, representative development, clinical applicability, clinical flexibility, clarity, meticulous documentation and scheduled review.[16] A scheduled review is very important to assure currency.

The steps listed by Browman[4] include selection and framing the clinical problem, generating evidence-based recommendations, ratifying the evidence-based recommendations, formulating practice guidelines, independent review, negotiating the practice policies, adopting the guidelines/policies, and a scheduled review of the guidelines. The American College of Physicians outlines steps used to determine if a guidelines is outdated.[17] They suggest looking at the methodology used to develop the guideline and conducting a MEDLINE search to retrieve research conducted after the guideline's publication date.

Most physicians are in agreement with practice guidelines in principle, but are far more resistant to the implementation. McNeill[18] notes that writing the practice guideline is only 10% of the effort, while implementation is the other 90%. Reasons for noncompliance include implementation issues, inefficiency of the health care system, and the severity of the illness.[19] Grimshaw[12] found that physicians were more apt to accept guidelines if

they were developed by a local group and were distributed by specific educational interventions. Just being aware of the existence of a guideline does not usually change a physician's behavior. A system of rewards and/or punishments is more successful.[20] However, Onion[10] notes that intrinsic motivation, which can be achieved through education or organizational process can be more effective than extrinsic methods, such as rewards or punishment. Greco[21] notes six general methods that can be used to alter the practice behaviors of physicians: education, feedback, involvement by the physicians in efforts to implement the change, administrative rules, financial incentives and financial penalties. A combination of these usually works best.

Practice guidelines can be accessed in a number of ways. Citations to those that have been published as journal articles can be retrieved from the MEDLINE database, using either the Grateful Med software or various other methods. (For further information accessing the MEDLINE database, contact a medical librarian.) MEDLINE includes "practice guidelines" as a publication type and a search on a topic can be limited to this publication type. "Practice guidelines" is also a MeSH (Medical Subject Heading) in MEDLINE. The subject search will retrieve articles on guidelines, as well as review articles and letters on the discussion of practice guidelines. A search of the MEDLINE database (covering 1966-October 1996) revealed 2055 articles with practice guidelines as a publication type and 2105 citations with practice guidelines as a subject heading. Those issued by organizations and agencies can be obtained directly from the organization. Also, the American College of Physicians annually publishes a text, *Clinical Practice Guidelines*.

In 1989, Congress established the Agency for Health Care Policy (AHCPR), whose goal is to enhance the quality, appropriateness and effectiveness of health care services and access to these services, including the development of clinical practice guidelines. The guidelines are mainly based on the published scientific literature. Thus far, AHCPR has issued clinical practice guidelines on 18 common ailments, with copies distributed nationwide. Topics include pain management, pressure ulcers, depression, sickle cell disease, HIV, cataracts, urinary incontinence, unstable angina, heart failure and low back pain.[22] The guidelines are evidence-based, "developed by private-sector multi-disciplinary panels of experts who distill from the vast body of published literature the most effective options for patient care."[23]

The AHCPR clinical practice guidelines are issued in three formats: full-text, a quick-reference guide for the clinician and a consumer brochure, and most are available in both English and Spanish. There are several methods of access for the clinical practice guidelines issued by AHCPR.[24] They can be obtained in print form without charge directly from the agency. (See Figure 1.) They are also available on CD-ROM from AHCPR. The AHCPR clinical practice guidelines can also be searched using the Grateful Med software program. (For further information of use of this software, contact a medical librarian.) There is no charge for this access method. Finally, they are available via the Internet using either gopher, FTP or World Wide

Web. The guidelines are word searchable using Grateful Med or via the Internet. (See Figure 2 for gopher and WWW addresses.) (For further information on access via the Internet, eontact a medical librarian.)

AHCPR has restructured its program and in the future will issue evidence reports from the Evidence-based Practice Centers, rather than the practice guidelines. Thc evidence reports will inelude literature reviews, evidence tables, deeision analyses, meta-analyses and other products. Thc evidence reports are designed to be used by public and private sector organizations in the development of local clinical practice guidelines. Additionally, AHCPR plans to work with national organizations to develop a public-private sector consortium that would support a national online database of clinical health practices. The database would include access information, summaries of the guidelines, full-text when available, and annotations comparing the processes and recommendations of multiple guidelines on the same topic.

The Internet itself is another source of praetice guidelines. A search of World Wide Web pages in October 1996 using the WebCrawler search engine revealed 244 practice guidelines, issued by both academic and commercial entities. InfoSeek, another search engine, retrieved 2070 WWW pages with the term practice guidelines, while Alta Vista retrieved >9000. To access these practice guidelines, some type of Internet connection is necessary. Using the various search engines and the term "practice guidelines," the guidelines can be retrieved.

Well developed, scientifically-based practice guidelines can improve the quality of health care and can be an enhancement to the physician's clinical skills. However, the practioneer must determine that sound methodology was used to develop the practice guideline. And it must be remembered that guidelines do not apply in all situations. The physician's judgment is still the most critical aspect of patient care.

U.S. Dept of Health and Human Services Public Health Service Agency for Health Care Policy and Research Executive Office Center, Suite 501 2101 East Jefferson St. Roekville, MD 20852 (301) 594-6662 Publications Clearinghouse - 1-800-358-9295

References

1. Medical Subject Headings — Annotated Alphabetical List. Bethesda, MD: National Library of Medicine, 1994.

2. Wilson, M.C., Hayward, R.S., Tunis, S.R., Bass, E.B., Guyatt, G.: User's guides to the Medical Literature. VIII. How to use clinical practice guidelines. B. what are the recommendations and will they help you in caring for your patients? The Evidence-Based Medicine Working Group. JAMA. 274(20):1630-2, 1995 Nov 22-29.

3. Hopkins, A.: Some reservations about clinical guidelines. Arch Dis Child. 72(1):70-5, 1995 Jan.

4. Browman, G.P., Levine, M.N., Mohide, E.A., Hayward, R.S., Pritchard, K.I., Gatni, A., Laupaci,s A.: The practice guidelines development cycle: a conceptual tool for practice guidelines development and implementation. J Clin Oncol. 13(2):502-12, 1995 Feb.

5. Woolf, S.H.: Practice guidelines: What the family physician should know. Am. Ram. Physician. 51(6):1455-1463, May 1, 1995.

6. Tunis, S.R., Hayward, R.S., Wilson, M.C., et al.: Internists' attitudes about clinical practice guidelines. Ann Intern Med. 120:956-63, 1994.

7. Saha, A.: Clinical guidelines [letter; comment]. BMJ. 310(6980):670, 1995 Mar 11.

8. Farmer, A.: Medical practice guidelines: lessons from the United States. BMJ. 307(6899):313-7, 1993 Jul 31.

9. Brennan, P.J., Abrutyn, E.: Developing policies and guidelines. Infect Control Nosp Epidemiol. 16(9):512-7, 1995 Sep.

10. Onion, COO., Walley, T.: Clinical guidelines: development, implementation, and effectiveness [see comments]. Postgrad Med J. 71(831):3-9, 1995 Jan.

11. Pauly, M.V.: Practice guidelines: can they save money? Should they?. Journal Law Med Ethics. 23(1):65-74, 1995 Spring.

12. Grimshaw, J.M., Hutchinson, A.: Clinical practice guidelines—do they enhance value for money in hearth care?. [Review] BMB. 51(4):927-40, 19950ct.

13. Lohr, K.N.: Guidelines for clinical practice: what they are and why they count. J Law Med Ethics.

23(1):49-56, 1995 Spring.

14. Basinski, A.S.: Evaluation of clinical practice guidelines. [Review] Can Med Assoc J. 153(11): 1575-81, 1995 Dec 1.

15. Battista, R.N. Hodge, M.J.: Setting priorities and selecting topics for clinical practice guidelines. Can Med Assoc J. 153(9): 1233-7, 1995 Nov 1.

16. Institute of Medicine. Guidelines for clinical practice: from development to use. Washington, DC: National Academic Press, 1992.

17. Clinical Practice Guidelines. Philadelphia, PA: American College of Physicians, 1995.

18. McNeil, C.: Clinical guidelines: implementing them won't be easy [news]. J Natl Cancer last. 88(8):488-90, 1996 Apr 17.

19. Ellrodt, A.G., Conner L., Riedinger M., Weingarten S.: Measuring and improving physician compliance with clinical practice guidelines. A controlled interventional trial. Ann latern Med. 122(4):277-82, 1995 Feb 15.

20. Ruddy, S.: Some guidelines about practice guidelines [editorial; comment]. Arthritis Rheum. 38(11): 15334, 1995 Nov

21. Greco, P.J., Elsenberg, J.M.: Changing physicians' practices. NEngl J Med. 329:1271-3, 1993.

22. AHCPR. [WWW Home Page]. Rockville, MD: National Institutes of Health, National Library of Medicine, Agency for Health Care Policy and Research; [date unknown; cited 1995, Nov 17, 1995], [2 screens].

23. Gaus, C.R.: From the Agency for Health Care Policy and Research. JAMA. 274(2):108, July 12, 1995

24. National Library of Medicine. Health Services/Technology Assessment Texts (HSTAT) Fact Sheet. [gopher] Rockville, MD: National Institutes of Health, National Library of Medicine, National Information Center on Health Services Research and Health Care Technology. [April 21, 1995], [3 screens].

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Physician Impairment and Health: A Brief Overview

*Larry S. Goldman, M.D.**

In 1972, the American Medical Association's (AMA) Council on Mental Health published its report,[1] "The Sick Physician," drawing the profession's and the public's attention to the problem of impaired physicians. The report noted that numerous articles had appeared in the medical literature during the preceding 15-20 years suggesting that substance abuse (including alcoholism), other mental disorders, and suicide were significant health problems among physicians. This AMA report called for (1) all physicians to take responsibility for impaired colleagues, (2) the referral of impaired colleagues to appropriate committees or boards in order to obtain treatment and to protect patients, (3) educational programs for medical trainees about these problems, and (4) the development and implementation of model legislation for states in dealing with impaired physicians.

Although "sick doctor statutes" were already on the books in Florida (1969) and Texas (1971), this report catalyzed a period of increased legislative and regulatory activity. It also led to the establishment of new programs to assess, treat, and/or monitor impaired physicians; new course offerings in medical schools and residencies to educate trainees and to attempt to "inoculate" them against this occupational hazard; and additional research to clarify the nature, risk factors, course, and outcomes for impaired physicians.

During this time (1970s and early 1980s) most of this activity was focused on alcoholism and other substance abuse, and the emphasis was on physician impairment and recovery from these substance use disorders after they had already taken their toll. Eventually every state had developed some program to deal with affected physicians, and as more physicians came (or were sent) forward into these programs, more clinical and epidemiologic information began to accumulate.

First, subsequent studies of addiction rates among trainees and practicing physicians suggested that overall, physicians' misuse of substances was not necessarily greater than that of nonphysicians of comparable age and other similar demographic factors.[2, 3] While rates of abuse of prescription drugs seemed to run somewhat higher, rates of illicit drugs were quite a bit lower.[4] Secondly, there was a growing appreciation for the occurrence in physicians of other mental disorders,

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particularly depression and bipolar disorder. These conditions were seen both as co-occurrent with substance use disorders or simply by themselves. Finally, there were other conditions which caused impairment that were not mental disorders or at least which did not fit well into standard psychiatric nomenclature. In the first group were physical infirmities, including cardiac, musculoskeletal, necrologic (stroke, MS, blindness, etc.), and other conditions.[5] The second category consisted of behavioral problems such as sexual exploitation of patients or abusiveness towards patients or co-workers.[6]

Many impaired physician programs were developed in conjunction with state medical societies. In some cases this was simply a small, voluntary committee of society members, but certain states began to develop more extensive programs with a professional staff and even medical directors. An ongoing tension has been the relationship between these programs and the state licensing boards.[7] The licensing boards, which are charged with a primary mission of public protection, have sought to know as much as possible about any cases of physician illness or impairment. Some states have created "diversion programs," which allow physicians to be referred to health programs without having to be reported to their state licensing boards. States with those arrangements have generally found that they are able to get more physicians to enter treatment voluntarily, often at earlier stages of their illnesses (i.e., before they were so impaired they did something to warrant licensing board reporting or action).[8, 9]

As these programs came to enjoy the trust of their licensing boards and of physicians, the scope of types of cases coming to the programs increased. This expanded clinical demand — along with the research findings mentioned earlier — has led the field to a shift from substance abuse and impairment to broader consideration of disorders of all types and incorporation of disease prevention and health promotion.

As the field of physician health has continued to evolve, there has been an ongoing need to disseminate new information about clinical practice, program development, and regulatory issues to practitioners, administrators, and educators. One forum for this dissemination has been a series of international conferences held every 1-2 years which are co-hosted by the AMA and the Canadian Medical Association. These three-day meetings, alternating between US and Canadian venues, generally bring together 300-400 people, mostly from North America and Europe, with an interest in physician health. The most recent conference was held February 7-10, 1996, in Chandler, Arizona. The conference included half-day updates (institutes) on psychiatry, substance abuse, and women's health, as well as five plenary speakers who discussed topics as diverse as women in surgery, spirituality, medical students, the Americans with Disabilities Act, and population-based medicine.

Presentations were held on stress in medical schools; managing medical and psychoactive drugs in recovering physicians; intervention strategies for physician health committees; monitoring physicians with personality disorders; fund-raising for physician health programs; national efforts to assist impaired physicians; and the effects of the "health care crisis" on physicians'

emotional health, among others.

The next such conference will be held April 29 - May 2, 1998, in Victoria, British Columbia, Canada. The theme, *Managing Our Own Care: Surviving the Health Care Revolution*, will emphasize the effects of the changing health care delivery system on physician well-being. The call for papers (deadline October 31, 1997) was open to a broad range of submissions, with a particular emphasis on: stresses related to changes in health care systems; primary prevention of illness and impairment; needs of particular physician populations such as trainees, older physicians, minorities, women, and IMGs; physical illness and disability; rehabilitation, restraining, and reentry; the relationship between physician factors and medical errors; physician and family self-care and reactions to illness or stress; reactions to bad outcomes and lawsuits; harassment of and by physicians; relationships among hospital programs, state programs and licensing authorities; and dealing with physicians who misprescribe.

For additional information on the conference call the AMA Department of Mental Health at 312-464-5066. Information can also be found on the World Wide Web at **www.ama-assn.org** or at **www-psy.bsd.uchicago.edu/~larry/uchome.htm.**

References

1. Council on Mental Health. The sick physician: impairment by psychiatric disorders, including alcoholism and drug dependence. *JAMA* 1972;223:684-687.

2. Brewster JM. Prevalence of alcohol and other drug problems among physicians. *JAMA* 1986;255:1913.

3. Hughes PH, Brandenburg N. Baldwin DC. Prevalence of substance abuse among US physicians. *JAMA* 1992;267:2333-2339.

4. Council on Scientific Affairs. *Substance Abuse Among Physicians.* Chicago: American Medical Association; 1995.

5. Corbet B. Madorsky JG. Physicians with disabilities. *West J Med* 1991,154:514 521.

6. Summer GL, McCrory E. Professional sexual misconduct. *Alabama Med* 1994;64:4-6.

7. Ad Hoc Committee on Physician Impairment. Report of the ad hoc committee on physician impairment. *Federation Bulletin* 1994;81 :229-242.

8. Casper E, Dilts SL, Soter JJ et al. Establishment of the Colorado physician health program with a legislative initiative. *JAMA* 1988;260:671-673.

9. Ziegler PP. The physicians' health programs of the educational and scientific trust of the Pennsylvania Medical Society. *Federation Bulletin* 1995; 82: 151 - 154.

Ethical Dilemmas

Ernest S. Campbell, M.D.

The following short vignettes are presented to stimulate discussion about the ethical and moral dilemmas that all physicians face daily. It is not meant to be an exhaustive discussion of the extremely variable and capricious laws promulgated by legislatures to satisfy various focus groups.

Ethical Dilemmas 1. Consent

Cases

Mr. Johnson is an 86-year-old man who is the care-giver of his wife, who has fairly severe Alzheimer disease. He has a large inguinal hernia which has been recommended for repair by one general surgeon; another physician told him that he "might never survive the operation." Mr. Johnson refused surgery, mainly because of his wish to provide uninterrupted care for his wife; however, he agreed to discuss the decision further with the surgeon at a future visit. Before such a visit takes place, however, Mr. Johnson incarcerates his hernia, becomes obstructed and is taken to the emergency department. Physical examination reveals him to be hypotensive and vomiting fecal content with a large irreducible tender inguinal mass. Mr. Johnson is barely conscious and incoherent. An obstructed incarcerated hernia is diagnosed and the surgeon believes that Mr. Johnson will die without emergency surgery. No relatives can be reached for consultation.

Mr. Jones, a 69-year-old nursing home resident, has severe Alzheimer disease. He is totally dependent on others to carry out all activities of daily living and is incontinent of urine and feces. He moans and cries and does not recognize his family members. He has had fever, a cough producing green sputum and shortness of breath for 48 hours. He is transferred to hospital for treatment of suspected pneumonia. His wishes regarding treatment for pneumonia have not been documented. The nursing home has already notified Mr. Jones' wife, who is now driving to the hospital and will soon arrive.

Clinicians often struggle with the question of how to apply the ethics of consent in their daily practice. It is helpful to distinguish the process of problem solving from that of decision making. Problem solving involves identifying the patient's presenting problem and developing a list of treatment options. Most patients expect the physician to assume the role of problem solver. Decision making involves choosing from the treatment options and patients should be free to ask questions and receive answers about treatment options not discussed by the clinician. The consent process also requires that patients actively participate in decision making and authorize the decision. Even if the patient is pre-

disposed to follow the clinician's recommendation, the clinician should actively engage the patient in the consent process.

Several studies have shown that patients' desire for decision-making responsibility is variable. Even patients who actively seek information do not necessarily wish to make the decision about which treatment option to follow. Some, particularly those who are elderly or acutely ill, are predisposed to follow the physician's recommendation.

Exceptions

Common law recognizes that the emergency treatment of incapable persons is an exception to the requirement for consent. In common law, an emergency exists when immediate treatment is required in order to save the life or preserve the health of the patient. The rationale for this exception is that a reasonable person would consent to the treatment, and that a delay in treatment would lead to death or serious harm. In most locales, for example, an emergency exists if a person is apparently experiencing severe suffering or is at risk and will sustain serious bodily harm if the treatment is not administered promptly.

The emergency exception to the requirement to obtain consent has important limitations. Clinicians should not administer emergency treatment without consent if they have reason to believe that the patient would refuse such treatment if he or she were capable, such as in giving blood to an unconscious Jehovah's Witness patient who carries written instructions regarding his/her care.

A patient's incapacity does not exempt the physician from the requirement to obtain consent. If a patient is mentally incapable of making medical decisions, the clinician must obtain consent from a substitute.

The cases

Since Mr. Johnson is now incapacitated and in a medical emergency, and no substitute decision-maker is available, the surgeon may proceed without the patient's consent unless a clear wish to the eontrary has been expressed earlier. Mr. Johnson's prior refusal of elective surgery was based on his wish to continue caring for his wife. Therefore, Mr. Johnson would likely want to undergo emergency surgery, because it would give him the best chanee of eontinuing to care for his wife. Therefore, the surgeon may proceed without the patient's consent. If Mr. Johnson had previously considered and refused emergency surgery, the surgeon would not be entitled to proceed.

Mr. Jones is obviously incapable of consenting to treatment of his pneumonia, and so the physician should obtain consent from Mr. Jones' wife. However, the clinician could administer emergency treatment such as oxygen and intravenous antibiotic therapy until Mr. Jones' wife arrives.

Further reading

I. Beauchamp TL, Faden RR. Informed consent: II. Meaning and elements of informed consent. In: Reich WT, editor. Encyclopedia of Bioethics. rev ed. vol 3. New York: Simon & Schuster Macmillan, 1995:1240.

2. Lidz CW, Appelbaum PS, Meisel A. Two models of implementing informed consent. Arch Intern Med 1988;148:I385-9.

3. Cassileth BR, Zupkis RV, Sutton-Smith K, et al. Information and participation preferences among cancer patients. Ann Intern Med 1980;92:832-6.

4. Emanuel EJ, Emanuel LL. Four models of the physician- patient relationship. JAMA 1992;267:2221-6.

5. Strull WM, Lo B, Charles G. Do patients want to participate in medical decision making? JAMA I984;252:2990-4.

6. Meisel A, Roth LH, Lidz CW. Toward a model of the legal doctrine of informed consent. Am J Psychiatry 1977;134:285-9

In Pursuit of Health

Richard C. Reuben, J.D.
In The ABA Journal

California general practitioner Mark Hiepler thought that the problem could be resolved with a simple letter.

His sister, schoolteacher Nelene Fox, had breast cancer, and her doctor wanted her to have a bone marrow transplant. But her health maintenance organization, Health Net, refused to pay for the $100,000 treatment, contending it was experimental at her advanced stage, and therefore not covered by her policy. Hiepler sent a letter questioning the decision, and then another, and another, each falling on deaf ears as his sister's condition worsened.

"I couldn't believe their arrogance," says a still-shocked Hiepler. The language was clear, but they just didn't want to pay for the treatment, even though there was a reasonable chance it would have saved her life if it had been done when her treating physician asked."

Hiepler, then just five years out of Malibu's Pepperdine law school and shoe-horning help for his sister into a busy associate's schedule, finally sued Health Net for refusing to provide treatment. He won an $89 million jury verdict that stunned the managed care industry, although it was later reduced in a settlement.

The award in 1993, however, came too late to help Fox, who had raised the money for treatment on her own but died eight months before the verdict.

Her now 34-year-old brother is still playing an Arthurian role. Hiepler's crusade includes more than 130 denial-of-treatment cases now pending and about 100 hours of pro bono work each month to field nearly 400 calls from disgruntled patients or attorneys seeking advice on how to handle the cases.

Since the Fox case made national headlines, media coverage of problems with HMOS and other managed-care entities has exploded. It has been stoked by a slow but steadily increasing stream of consumer complaints about delays in or denials of treatment as experimental, unnecessary or beyond coverage — and more multi-million-dollar plaintiffs' verdicts, including several key cases by Hiepler.

"We're far from the peak of this kind of litigation," laments Dave Willett, a California medical-care defense lawyer, echoing other industry attorneys. In fact, some managed-care insurers have begun stoking their reserves in anticipation of a wave of denial-of-treatment-related claims, as the nation continues to undergo a fundamental shift in the way health care is funded, organized and administered.

There is less personal association between the patient and physician, and when that personal relationship is gone, people don't feel as kindly as they did when things go wrong, making them more inclined to sue, says Willett of Hassard Bonrungton in San Francisco.

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Richard C. Reuben, a lawyer, is a reporter for the ABA Journal.

But there are other forces building this tide, including the ever more cost-cost-conscious treatment orders by managed-care decision-makers and the fantastic growth of the industry. Thanks largely to employer-sponsored plans, nearly 150 million Americans received their health care through HMO and other managed-care entities in 1995 — an increase of more than a third from the 91.8 million enrollees in 1992, according to the American Association of Health Plans.

Similarly, more than half of this countrys physician's now do at least some managed-care work. Both patient and physician enrollments are expected to grow.

Managed-care advocates praise its cost controls on treatments for beginning to tame the health care beast, which devoured nearly 14% of the nation's gross domestic product in 1994, according to the U.S. Department of Health and Human Services. Such belt-tightening is necessary to allocate health care dollars rationally, advocates contend, pointing to direct patient costs as proof that a healthy balance has been achieved.

But critics contend that managed care is more about making money than saving it. Even though costs have gone down, they argue, premiums have remained high and corporate profits have soared. More significantly, they charge that managed care delivers second class treatment because of the way doctors in the plans are compensated.

Because of a financing arrangement called "capitation," which sets a fixed fee per patient, and broad incentives to reduce costs, critics claim doctors have powerful inducements to scale back on treatments and hospital stays, and to limit referrals to specialists. Managed-care providers deny it.

For many sick patients, the decisions on treatment can be shocking, frustrating, painful and, in cases like Helene Fox's, deadly. They can be equally vexing for doctors, who are often thrust into a Hobson's choice among potential malpractice for undertreatment, paying for treatment themselves if they have exhausted capitation amounts, or banishment from HMO rosters for overtreatment.

This in turn is breeding resentment among doctors for what they see as the usurpation of their judgment and independence by cost-conscious executives or, worse yet, nonmedical support staff.

The tension among the parties is becoming more palpable by the day, as lawyers for doctors, patients and managed-care entities are doing battle on a variety of fronts in the courts and legislatures—including questions of HMO liability, legal debates over medical judgments, and the prospect of physician actions against HMOs—that will establish the future contours of managed-care liability.

In the erstwhile fee-for-service era, lawsuits were relatively straightforward: The doctor performed the services and was the primary target for litigation when something went wrong. But managed care has changed that dynamic dramatically, and is beginning to replace the doctor as the deep pocket of choice in medical-care litigation.

But it is a choice fraught with peril, as suing an HMO for the denial of treatment or payment for services is much more difficult and complex than yesterday's medical malpractice cases. Many HMOs require the mandatory arbitration of treatment and other claims, which keeps such matters out of court unless the arbitration provi-

sion can be trumped.

ERISA Pre-emptions

State law claims, moreover, are often pre-empted by the federal Employee Retirement Income Security Act, given the U.S. Supreme Court's broad view of ERISA preemption of legal issues "related to" employee benefit plans This is significant because punitive damages generally are not available in actions governed by ERISA, and because federal courts are often considered to be friendlier to managed-care defendants than to plaintiffs.

While the trend for now appears to favor ERISA pre-emption of state law claims against HMOs arising from employee health plans, courts are still splintering on the details of an issue that is often one of the first points of contention in an HMO suit. Most experts say the U.S. Supreme Court will ultimately have to decide the scope of ERISA pre-emption in the HMO context to establish uniform rules.

Regardless of venue, however, managed-care entities have historically benefited from the so called "corporate practice of medicine" doctrine. The doctrine essentially bars direct malpractice lawsuits against most types of HMOs and managed-care entities on the theory that they are not corporations formed to practice medicine; rather, they are formed like insurance companies just to pay for the treatments. Like ERISA pre-emption, the application of the doctrine is often an early battleground, as attorneys parse organizational charters and related facts to determine the scope of an HMO's legal authority.

With clients at their doors, plaintiff's lawyers have used two other central theories to scale the often statutory corporate-practice-of-medicine wall—vicarious liability and corporate negligence—although the growing number of judicial decisions on motions for summary judgment continue to conflict.

Domenick C. DiCicco Jr., a Philadelphia litigator who handles matters for CNA Insurance Cos., says a managed-care entity's agency liability is real, that it is going to depend on the nature of the relationship between the doctor and the entity.

"The more HMOs exercise control over their participating physicians, the more their exposure to liability for the torts of the doctors will continue to increase," maintains DiCicco, of Simasek, Ruzzi & McKee. "Many of the complaints are ridiculous and get dismissed rather easily, but other times you just have to wonder what [the HMO] was thinking," he says, calling the liability issue "a disaster waiting to happen."

HMOs that hire doctors as full-time employees have generally been found liable under a respondent superior theory much as any other company would be liable for actions of its employees. Some courts, such as the U.S. Court of Appeals for the District of Columbia in *Schlier v. Kaiser Foundation Health Plan*, 876 F.2d 174 (1989), have extended this rationale to find HMOs vicariously liable for the negligence of consulting physicians.

The majority of HMOs present harder cases because the doctors are independent contractors rather than staffers. This means the HMO can only be held liable for a doctor's misconduct if the doctor was an "apparent" or "ostensible" agent of the HMO.

Experts agree this is an expensive, fact-intensive inquiry, which requires a

plaintiff to show that he or she looked to the HMO rather than the individual physician for care, and that the HMO held out the physician as its employee, creating a reasonable presumption in the eyes of the patient that the physician was the agent of the HMO.

Advertising and marketing efforts can be crucial evidence in this determination, and can give rise to fraud as well as other forms of liability. In one case, for example, an HMO patient who had to have an arm amputated, after a misdiagnosis based on a consulting radiologist's report, was allowed to sue the HMO for malpractice largely because it promised plan members "complete health care services." *Decker v. Saini*, WL 277590 (Mich. Cir. Ct. 1991).

On the other hand, an Illinois HMO was able to avoid apparent agency liability, in part, by specifically informing patients that it does not provide medical services. *Raglin v. HMO Illinois, Inc.*, 230 Ill. App. 3d 642 (1992).

Larry R. Rogers Sr. of Powers, Rogers & Lavin in Chicago, who represented Gerik Raglin in a claim for damages arising from the troubled pregnancy of his mother, said the court's decision was driven by the corporate-practice-of-medicine doctrine. He also called "for an appropriate legislative remedy so HMOs cannot avoid liability by setting up corporations under acts that provide them the immunity from liability that they now enjoy."

In the past, employers have typically weighed competing health plans primarily by cost, rather than quality, according to plaintiff's lawyer Hiepler. "They're acting as a fiduciary for their employees when they select plans," Hiepler says. "But if they don't engage in a due diligence inquiry on quality, then they may be subject to liability."

While this theory of liability is just emerging, HMO liability for corporate negligence is further along. The idea is that HMOs owe a duty to patients to exercise reasonable care in ensuring the competence of physicians and staff they hire or approve, as well as in maintaining facilities. The theory has been applied to hospitals since the mid1960s, and has been extended to HMOs since the late 1980s. *Harrell v. Total Health Care, Inc.*, 781 S.W. 2nd 58 (Mo. 1989).

As with apparent agency, this approach is costly, fact-intensive and unpredictable as courts work their way toward consensus rules. It may also be more difficult than the agency theory for plaintiffs, in that they have to show the HMO was legally negligent in selecting its physicians and managing its staff and facilities, rather than that a physician was negligent in a given situation.

Still, experts see direct corporate negligence liability taking root with increasing speed. For example, a Pennsylvania appeals court upheld a corporate negligence action against an HMO for failing to properly screen a physician whose patient died of cancer after the doctor failed to get a biopsy or perform follow-up treatments.

In so doing, the court said an HMO that uses independent contract physicians owes its patients a duty to "select and retain only competent physicians" and to "formulate, adopt and enforce adequate rules and policies to ensure quality care" for its patients. *McClellan v. Health Maintenance Organization of Pennsylvania*, 442 Pa. Super. 504 (1995). Failure to meet such duties, the court said, will subject an HMO to

direct corporate liability.

Indeed, a jury in Cuyahoga County (Cleveland), Ohio, slapped an HMO with a $1.25 million verdict on a corporate negligence theory for a doctor's failure to diagnose a cancerous lung tumor, and the verdict was affirmed on appeal. *Isbell v. Kaiser Foundation Health Plan,* 619 N.E.2d 1055 (Ohio Ct. App. 1993).

"The agency principle is a long-standing one, but corporate negligence is where it's really starting to come down," defense lawyer DiCicco says. Recent trial court rulings, he adds, Have made it clear that HMOs are going to be on the hook for direct corporate negligence."

Paul Herrington III, insurance counsel for a national HMO, says most denial-of-treatment complaints against HMOs arise from two situations: Either the HMO considers a treatment experimental or unnecessary, or it is not covered by the HMO policy.

"You may really need eyeglasses or a stay in a rest home, but that doesn't necessarily mean that it's covered by the policy or that the HMO is going to pay for it as medically necessary," says Herrington, chair of the ABA's new Health Law Section.

Patients who disagree with a coverage issue can generally appeal within the HMO, which often resolves the problem. "A lot of people just think insurance covers everything," Herrington says. "When you show them why something wasn't covered by the policy, they tend to understand. They may not be happy, but they understand."

To safeguard consumer loyalty and goodwill, HMOs frequently cover matters that they don't have to, Herrington adds.

Into the Fray

Lawyers are increasingly being brought into play at the earliest stage, when internal review is sought for an HMO'S decision to deny treatment on the basis of lack of medical necessity or experimental treatment—even though decision-making at this point tends to be driven far more by medical factors than legal considerations.

James Griffin, a Westbury, N.Y., solo practitioner who has handled several denial-of-treatment cases, says this stage is much like any other negotiation, requiring fact-gathering, phone calls, letters and strategies—except that speed is particularly important.

"This is about getting the patient the care that's necessary as soon as possible, not about ultimately winning a lawsuit," he says. His added advice: It's wise to let the HMO know you are demanding review on an expedited basis because your client isn't getting the necessary treatment."

One common criticism of the review process is that the boards either are composed of business people or physicians who are personally or institutionally beholden to the HMOs, and therefore have a financial incentive to rule in favor of the HMOs. It is a criticism HMO attorneys strenuously deny.

Rather, they contend, debates over medical treatment by review boards simply mirror similar debates within the medical profession itself.

For example, women in the United States undergo hysterectomies at a rate about five times that of other developed countries. At an average cost of $5,000 an operation, HMOs are increasingly scrutinizing requests for the surgery while looking at other treatment options.

How long women who have given birth should be allowed to remain in a

hospital is another point of contention. After public outcries over widespread practices of discharging new mothers within 24 hours of delivery, more than 20 states have enacted statutes requiring hospitals to allow post-delivery stays of at least 48 to 96 hours.

But Herrington insists such instances are "not a question of bad faith." Rather, they reflect "serious, well-founded debate within the medical community" over proper medical care. Other examples of often requested, often denied treatments include bone marrow transplants, psychiatric-related therapy and temporomandibular joint surgery for headaches.

But Hiepler says the argument sweeps too far. "It's the best way for an HMO to ration care without saying so," he argues. They do not want to specifically exclude anything, so they put in words like 'experimental' or 'investigational' or 'medically necessary' that have no meaning, and can't be defined, to provide a label for anything they don't want to pay for."

Therein lies the gulf between the camps, and when the brawl spills over from the utilization review board into the courtroom, the results are predictable. Plaintiff's lawyers who have been successful in surviving the HMO's summary judgment motion ply juror emotions, while HMO lawyers battle a negative public image in contending that a treatment wasn't medically necessary or was experimental and, therefore, excluded from the policy.

In the end, "It's very much a battle of the experts," says medical defense litigator Davis Carr, III of Carr, Alford, Clausen & McDonald in Mobile, Ala. "Denial-of-treatment cases are not unlike medical malpractice cases in that, in almost every case, you have the physician's judgment at issue, with someone disagreeing with or second-guessing someone else's judgment."

Doctors Suing HMOs

This "second guessing" is increasingly what gives rise to agency liability for HMOs, as well as a rising level of litigation unknown in the old fee-for-service system: doctors suing HMOs and other managed-care entities.

Doctors are, quite literally, caught in the middle in the battle over treatment between patients and HMOs. They are finding themselves in the position of being patient advocates when the HMO says no.

"We advise [doctors] it's imperative they properly document what they're asking for, and what led them to their conclusion that it's necessary," says Timothy A. Johnson of Gardner, Carton & Douglas in Chicago, a firm that represents both doctors and managed-care entities. "I, for one, believe that managed-care entities don't want the malpractice liability, the bad faith accusations, the bad publicity, and really just need for doctors to properly document what they're doing. Too often, that's just not done."

The issue of the impact of HMO decisions to deny treatment on medical malpractice standards is still largely uncharted territory. But most experts for now agree that the primary duty of care is that which a reasonable physician in the community would have provided, regardless of HMO decisions about payments for services.

This puts the doctor in the awkward position of either going forward with a procedure that won't be reimbursed by the HMO or the patient, or being subjected to malpractice liability

if something goes wrong for failing to carry out a treatment he or she wanted to do. Not surprisingly, many doctors prefer to reduce the risk by paying the costs of the denied treatment out of their own pockets.

As those costs continue to rise, however, some attorneys see the need for whet may someday be called the "HMO made me do it" defense to a physician's malpractice liability.

"If a treatment decision is not made in good faith and is made for economic rather than medical reasons, there should be some form of redress for the physician," says Michael Goldring, a Fresno, Calif., lawyer who represents doctors and other medical care providers.

While such an argument may have emotional sway with a jury, no court is believed to have yet endorsed such a defense in a published decision. But that day may be coming as more such complaints are filed, and as the relationship between providers and managed care entities continues to rupture.

In the meantime, Goldring says physicians in such situations do have remedies. "I would try to bring the HMO into the original suit on a cross complaint and handle it there," he says. "The idea is, 'You turned me down, your decision was wrong, and I think you should stand up here with me and take some of this fault.'

"Yet, doctors are timid about taking such a course of action, just as they are loathe to advocate too vigorously on their patients' behalf when the HMO denies treatment. HMOs, after all, have the power of the purse, and many physicians are openly fearful of making decisions or taking positions that would lead to them being cut off from the financial umbilical cord of approved provider status," says Goldring.

"Doctors who are seen to be overutilizers are being tossed out of the plans, and as the numbers become more significant, those decisions will likely be litigated because they are about professional survival," says Jay Christiansen, an attorney with Faegre & Benson in Minneapolis, Minn.

Many doctors work with many different HMOs, so a decision by the HMO to remove them from the list may not be that economically disastrous. "It depends on what percentage of practice is being terminated," says Goldring.

For example, he says, a physician who loses 5% of business after being released by one HMO for overutilization may not feel it's worth the fight to challenge that action. However, losing 50% or more of business might make litigation a necessity of survival—a prospect increasingly possible as the managed-care industry begins to consolidate.

Like patients denied treatment, however, such doctors are plaintiffs in search of a theory, as early generation federal antitrust and RICO claims, and state law claims for tortious interference with prospective economic advantage by excluded doctors have generally failed to survive motions for summary judgment. *Hassan v. Independent Practice Associates*, 698 F. Supp. 679 (1989).

Most physicians or physician groups have contracts with HMOs that provide for periods in which either party can renew or terminate the relationship without cause.

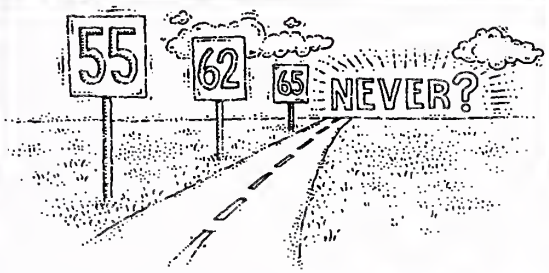
But at least one state supreme court has ruled that the refusal to reappoint a surgeon to a panel after 10 years with the HMO could violate public policy, and permitted the surgeon to challenge the decision on the ground that the termination violated the

implied covenant of good faith and fair dealing traditionally read into contracts. *Harper v. Healthsource New Hampshire*, 674 A.2d 962 (1996).

"I see this as a brand new area of litigation," says Hiepler. "You don't have state caps on punitive damages, you don't have to worry about possible ERISA pre-emption, you don't have any arbitration clauses."

And, he adds, "There is the potential for huge damages because you're able to argue to a jury that this is a doctor who just wanted to treat patients, but the HMO only wanted doctors who wouldn't give patients adequate treatment."

It likely won't be the last new area, as managed-care litigation only promises to expand, with issues yet to be conceived as plaintiff's lawyers work to get into HMO pockets—and managed-care lawyers fight to keep them out.



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J. Marion Sims

A Study of the Alabama Years and the Treatment of Vesico-vaginal Fistulas

Paul S. Howard, M.D.

The Alabama River drifts southward through the lowlands giving rise to the city of Montgomery. The city is typical of the black belt, as the soil deposited by the aging river is suited for growing inland green-seed cotton. The river deposits not only nutrients for cotton but also provides the means by which it is transported to Mobile and ultimately to fashionable garment makers in Europe. The mighty river is capricious as its muddy waters periodically flood the lowest areas of the city bringing the malarial fevers of summertime.

In the early morning as the riverbank awakens, when it is still cool, sticky and damp on the water, and the floating debris is camouflaged by a tenacious fog on the river surface, the slaves on Mr. Wescott's plantation begin the workday in the cotton fields. One of Mr. Wescott's slave girls will not work today as she has been suffering with a difficult pregnancy for the last three days. Each day and night the mistress of the plantation and an elderly slave known only as the "doctor woman" attend her. Both of these proud women had attended many difficult confinements but Anarcha was only seventeen and was as yet without child.

The birth of children in the slave population was generally an uneventful and mostly pleasant event. Mr. Wescott afforded nubile females incentives for the birth of healthy children and these incentives were not taken lightly.

On this steamy summer day in early June, 1845, Anarcha's misery became inconsolable and Mr. Wescott summoned Dr. Henry from town to see her. Dr. Henry, being one of Montgomery's oldest and most respected physicians, had contracted years before with Mr. Wescott to care for the slaves as well as Mr. Wescott's family. Upon examination of Anarcha, Dr. Henry immediately knew the dire situation that existed and was fearful of losing both mother and child. The elder doctor was aware of the newer techniques available for treatment of difficult confinements and consulted with a younger colleague who had only recently moved to Montgomery from Cubahatchee Creek, J. Marion Sims. Sims had reportedly developed a reputation as being a facile surgeon with the additional skill of being trained in the use of delivery forceps.

Sims, agreeing with the conclusion of Dr. Henry, applied forceps to the unborn slave infant and was able to deliver a healthy baby boy, although some injuries to the birth canal were evident.

Anarcha improved rapidly from her confinement and easily fed her infant son until five days had elapsed. She was suddenly unable to hold her water. The young mother found herself devastated, as the care of her child had to be given to another. In the

malarial heat of a lowland summer she had urine running from her day and night, saturating her clothes, the bedding, and producing a most disgusting smell when the whole of it was heated by the humid daytime. The heat and the urine in combination produced a painful inflammation of her external parts which became confluent similar to small pox. The odor permeated her small shanty, it clung to window and door and even seeped from the house following whatever breeze might sweep the riverbanks. Death would have been preferable. But as Dr. Sims knew, patients of this kind never die; they must live and suffer. Anarcha had a vesico-vaginal fistula.

J. Marion Sims' successful attempt to develop a surgical cure for Anarcha and other women who endured the torments associated with vesico-vaginal fistulas shaped his subsequent career and resulted in his recognition as the founder of modern gynecology. But it is unlikely that Sims would have predicted such a future for himself.

Born January 15, 1813, in Lancaster District, South Carolina, Sims was educated in the classical sense at South Carolina College and received his medical education at the Medical College of South Carolina and Jefferson Medical College in Philadelphia.[1] Unlike some other graduates of the prestigious Jefferson Medical College, Sims did not seek the clinical instruction in medicine and surgery that European medical centers offered. Since American medical schools did not provide the experience at the bedside of hospital patients that was available in Europe, the training Sims received in obstetrics and the function of the female reproductive system was based on reading and lectures rather than practice.[2]

After his graduation in 1835, he practiced medicine for a short time in Lancasterville, South Carolina, before joining others from his native state whom sought a new life in the fertile lands that awaited settlers in Alabama. In 1836, he settled in Mt. Meigs, a small town on the main road in eastern Montgomery County. A year later an opportunity arose near Cubahatchee Creek, a tributary of the Tallapoosa River in Macon County, and Sims moved his family to this new location, about ten miles east of Mt. Meigs. By the summer of 1840, Sims had succumbed to malaria, the "intermittent fever" which was endemic to the lowlands in the Cubahatchee Creek area. Sims reported in 1839 that, "I had all the practice I could possibly attend to,"[3] but he was forced by recurring bouts of malarial fever and a chronic intestinal disorder (dysentery) to move his family and practice from the swampy lowlands to Montgomery. This was the first of several moves made by Sims and his rapidly enlarging family with the support of his wife, Theresa, for the purposes of improving his chronic and recurring diseases. (He almost died of malaria and was saved by a pharmacist rather than a physician, who had access to the new drug quinine.) He later moved to New York City, mainly, again, to search for improving health.

Both Sims and his biographer, Seale Harris,[4] mention that a large portion of Sims' medical practice was obtained from large plantation owners in Alabama's "Black Belt." This prime cotton-producing region of Alabama was one of the most populated areas of the state in the mid-nineteenth century. It describes an arc across Alabama, extending from

Chambers, Macon and Russell counties in the east through Montgomery, Lowndes, and Dallas counties in the center of the state to Marengo, Pickens, Greene and Sumpter counties in west Alabama. It is served by an extensive river system which provided a cheap method of transporting the cotton harvest to Mobile, the cotton-trading and economic center of the state in the years before the Civil War. During the time Sims lived in Alabama, Mobile was also the center of the state's slave trade. An 1834 visitor to the state remarked that "to sell cotton in order to buy Negroes – to make more cotton, to buy more Negroes, 'ad infinitum,' is the aim and direct tendency of all the operations of the cotton planter."[5]

The number of African-Americans in Alabama increased from 42,024 in 1820 to 342,884 by 1850[6] and, in Black Belt counties made up from sixty to ninety percent of the total population.[7] Part of this explosive growth was due to slave trade and part was due to a natural increase in the slave population. Slaves represented a significant proportion of the assets of their owners. By 1860, the price of a good field hand in Alabama had risen to the enormous sum of $1,600.[8] Consequently, slave owners often employed a reward system to encourage childbearing by female slaves. The planters' desire to promote large slave families, the prevalence of disease in the slave population, and the relative lack of physicians trained in obstetrics provided Sims with the potential for developing a lucrative slave practice in Alabama.

Plantation owners struggled to make their estates self-sufficient in part by controlling expenses including health care costs. The plantation mistress frequently found herself in charge of the medical care of both her own family and of the slaves. She typically received her medical information from current planters' journals, including *Southern Cultivator*, *DeBow's Review, American Cotton Planter,* and *Soil of the South*, or from home health care advisory books such as *The Married Lady's Companion* or *Poor Man's Friend*. Many plantations also had a female slave called the "sick nurse" or a "doctor woman" who was prized for a lifetime of accumulated wisdom on practical medical matters. These women often acted as midwives for the slaves.

Between 1840 and 1845, Sims had developed a lucrative medical practice based primarily on his surgical skills. Sims was described by his friend and contemporary, the famous surgeon Samuel D. Gross, M.D. (1805-1885) as "a bold operator, sometimes to the point of recklessness, but he thoroughly understands the nature of his cases, and carefully weighs the consequences of the employment of the knife, which he wields with consummate ability."[9] He had proven himself an able operator in many areas, and had published a method of repair of bilateral cleft lip and palate.[10] He also reported the repair of many cases of strabismus and clubfoot.[11] Many of his early surgical patients were African-American slaves, including Sam and Jack,[12] from whom Sims successfully removed malignant facial tumors without the benefit of anesthesia. But it was Sims' experience with the unfortunate Anarcha that altered the course of his career.

Vesico-vaginal fistulas occurred with some regularity among slave women. Prolonged, difficult labor followed by traumatic delivery tech-

niques were the proximate cause of this condition; but pelvic rickets resulting from vitamin D deficiency may well have been the underlying cause of lengthy confinements. When ante-bellum physicians spoke of "infirmities peculiar to women" they noted that slave women suffered labor problems to a much greater extent than whites. Even with what appeared to be a nutritionally adequate diet, African-American slaves may have been likely to suffer from rickets due to geneticall-ly linked lactose intolerance.[13] As late as the 1950's black women still suffered from deformed pelves as a result of childhood rickets at a rate of seven and one-half times that of white women.[14] Other factors may also have played a part in the greater incidence of vesico-vaginal fistula among slave rather than white women in Alabama. Teenage mothers like Anarcha might not have been fully developed and could have had a pelvis too small to accommodate the baby's head. Gestational diabetes could also have produced cephalopelvic disproportion. Furthermore, women affected with sickle cell disease are subject to pelvic deformities that would result in problems at delivery.

The antebellum South was a tumultuous place in the years preceeding the Civil War. Politics, States' Rights, Federalism and slavery issues permeated the countryside. The rights of men remained unreconciled with the enslavement of the Negro population. Just as Thomas Jefferson had penned the Declaration of Independence but maintained slaves at his Virginia estate, physicians of the time were unable to reconcile providing medical care to slaves, usually without consent (except from their owners) at a level equivalent to freemen. In fact, many physicians of that time, including Alabama's own Josiah C. Nott,[15] proposed revisionist evolutionary ideas that slaves and whites evolved by parallel paths leading to the master-slave circumstances of that day. A separate medicine for a different kind of human was the call from many physicians.

Although Sims was clearly a man of his times, and a man known to put pen to paper, there is no written evidence extant that he was any more or less a racist than the average Southerner. The answer to the question whether or not he participated in the surgical experimentation on slaves for personal aggrandizement is available only by deduction.

Sims' accomplishments when bracketed in an historical framework, prior to Lister's antisepsis, prior to Louis Pasteur (1822-1895) and simultaneous to the advent of anesthesia, are indeed important if not remarkable. Social and ethical imperatives that result from a study of Sims' work merely add another dimension to the legacy of one of Alabama's most famous physicians.

We don't truly know what ever became of Anarcha Wescott. In his autobiography, Sims stated that he was able to cure Anarcha, Betsy and Lucy, his first three slaves who presented with vesico-vaginal fistula. It is clear that each of these young slave girls endured great pain rather than live with such a despicable deformity. Surgery performed without the benefit of anesthesia was all that was available in 1845, and therefore every procedure was in its own way "human experimentation." But to offer hope where there previously was none and effect a cure where no cures had previously existed is the goal and dream of every

great surgeon – it remains the same today.

References

1. J. Marion Sims, *The Story of My Life*, New York: Da Capo Press, 1968.

2. Steven M. Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth Century American South," Bulletin of the History of Medicine, vol. 64, no. 4, Winter 1990.

3. J. Marion Sims, *The Story of My Life*, New York: Da Capo Press, 1968, p. 190.

4. Seale Harris, *Woman's Surgeon – The Life of J. Marion Sims*, New York: The MacMillan Co., 1950.

5. Joseph Holt Ingraham, The South-West, By a Yankee, 2 Vols, New York: Harper & Bros., 1835, 2:91.

6. William Warren Rogers, Robert David Wood, Leah Rawls Atkins, Wayne Flynt, *Alabama-The History of a Deep South State*, Tuscaloosa, AL: The University of Alabama Press, 1994, p. 103

7. Ibid, Rogers, p. 98.

8. Ibid, Rogers, p. 105.

9. Samuel D. Gross, *Autobiography of Samuel D. Gross, M.D.*, Philadelphia: George Barrie, Publisher, 1887. Vol II, p. 153.

10. J. Marion Sims, "Double Congenital Harelip-Absence of the Superior Incision and Their Portion of the Alveolar Process," Am J Dent Sc, 5:51-56, 1844.

11. Ibid, Sims, *The Story of My Life*, p. 207.

12. J. Marion Sims, "Removal of the Superior Maxilla for a tumor of the Antrum. Apparent Cure. Return of the Disease." Second Operation. Sequel." Amer J Med Sc, April 1, 1847.

13. Kenneth F. Kiple, Virginia Himmelsteib King, *Another Dimension to the Black Diaspora: Dirt, Disease, and Racism*, Cambridge University Press, 1981, p. 163.

14. John Duffy, The Healers-A History of American Medicine, University of Illinois Press, 1976, pp. 139-143.

15. Paul S. Howard, M.D., "The Enigmatic Josiah C. Nott of Mobile: Physician, Surgeon, Educator, and Racial Theorist," Alabama Medicine, Vol 65, Fall, 1995, pp. 19-22.

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How Health Insurance Mandates Misdiagnose the Disease

From "The Backgrounder"
The Heritage Foundation

Two recent developments in Washington underscore just how badly many policymakers misunderstand the root cause of the public's frustration with the health care system. At first glance, both developments seem sensible, as well as overdue. But both completely miss the point, and may even make things worse.

The first is President Clinton's decision to appoint an Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The goal is "to find ways to ensure quality, and to ensure that the rights of consumers in health care are protected," and develop a "consumer bill of rights." The second seemingly reasonable development is the announcement of several bills that would require health insurance companies to cover services that most Americans believe should be in their health plans. Specifically, Senator Alfonse D'Amato (R-NY) and Representative Susan Molinari (R-NY) are sponsoring bills that would require insurers to cover minimum hospital stays for mastectomies. Other measures would mandate coverage of certain emergency services and lift contractual restrictions contained in physician contracts in some managed care plans to limit physician communication with patients (known as "gag clauses").

WRONG DIAGNOSIS

The problem is that these proposals, particularly the mandate bills, rush to cure the symptoms of the disease without recognizing its causes. The underlying problem is that typical working Americans do not choose and own their health insurance as they do their homeowner's insurance and life insurance. Instead, employers choose and own the plans. That part of the employee's compensation earmarked for a health insurance fringe benefit is tax-free to the employee, but there is a stiff price: Families lose control of their benefits. So insurance companies work for employers, concerned primarily with keeping costs down by trimming benefits, rather than for families concerned with quality and service.

Given this arrangement, families cannot do what they normally do when they are dissatisfied with a product or service: change to another company. Instead, the only way powerless families can force insurers to focus on their needs is to persuade their employers to change plans or hope the U.S. Congress will enact a mandate. That is why there is support for mandates. Yet mandates miss the underlying point: As long as the tax system effectively locks working Americans into employer-sponsored health coverage, families will be frustrated with how

they are treated by health insurers.

Even as a Band-Aid "solution" to this much deeper problem, mandates raise a host of problems and unintended side effects.

(1) Mandated benefit laws increase the cost of health care and make insurance even less affordable and accessible for many needy individuals. This effect is particularly troublesome for the 40 million Americans currently uninsured for some period each year. Over 1,000 such laws have been enacted at the state level, each requiring that a specific benefit, procedure, or provider service be covered in every state-regulated insurance policy sold. The costs of these mandates vary from state to state, but can be heavy.

Example. The U.S. General Accounting Office (GAO) estimates that mandated benefit laws account for 12% of claims costs in Virginia and 22% in Maryland.[1]

Example. The Congressional Budget Office (CBO) estimates that the federal law enacted in 1996 requiring private health insurers to cover 48-hour maternity stays will cost the federal government $223 million over four years, and that direct private-sector costs (increases in health premiums paid by employers and employees) will increase by $745 million over four years.[2]

Example. According to the CBO, the mental health parity legislation adopted in the last Congress will increase the federal deficit by an estimated $590 million over six years. This is due to increased costs to the Federal Employees Health Benefits Program (FEHBP), which covers federal workers and dependents, and lost tax revenue because of lower employee compensation (because employers will reduce wages to accommodate increased health plan costs). The CBO's preliminary estimate is that this provision will raise private-sector costs by more than $100 million over this same period.[3]

(2) Mandated benefit laws, particularly laws that define the duration and scope of specific benefits, lock in a standard of care that may be inappropriate in the future. This is the case with proposals like 48-hour maternity stays or required coverage of inpatient stays for mastectomies. Once these mandates are in statute, it becomes very difficult to change insurance benefits later, when state-of-the-art medical practices change. It entails national debate, protracted lobbying by interest groups, opposition from interests favoring the old mandate, and an act of Congress. Imagine, for example, that Congress had enacted legislation in 1980 requiring insurers to cover mothers and newborns in an inpatient setting for the average length of stay for a normal delivery at that time (77 hours).[4] Any attempt to amend that law today so that resources could be used for more appropriate medical benefits would face heavy opposition from hospitals specializing in maternity care.

Members of Congress must realize that mandating a sensible practice today means locking in what could become a costly, outmoded practice tomorrow. Thus, mandated benefits can impede progress, innovation, and improvements in the delivery of health care. Dr. Janet Roberto, a family physician, explained the problem at a recent congressional briefing. Benefit mandates imposed ostensibly to help doctors and patients, noted Dr. Roberto, can impede the doctor-patient relationship by creating a situation in which the patient, whose insurance

offers something different or more comprehensive, begins to question the physician's judgment regarding what treatment is best. "When a patient knows of a benefit that is mandated or in their terms 'automatically covered,' they immediately utilize that service as a need, whether it is or is not personally in their best interest.... Mandates can, in effect, take away the physician's judgment as to what is best for the patient."[5]

(3) Although mandated benefit laws do not prohibit advances in medicine directly, they can diminish the incentive to find new and better ways to deliver care. Nurse Lillie Shockney of Johns Hopkins University Hospital in Baltimore, Maryland, recently testified before the Maryland state legislature on the politically charged issue of outpatient mastectomies. Shockney is both an oncology nurse caring for cancer patients and a double mastectomy breast cancer survivor. She spoke of the Johns Hopkins outpatient mastectomy program's success in discovering improved treatment modalities for breast cancer patients, testifying that the program's emphasis on outpatient mastectomies was due to effectiveness and patient satisfaction, not to pressure from managed care. Advances in anesthesia, as well as a recognition of the primary role that family support plays in the healing process for breast cancer victims, have allowed Johns Hopkins to convert the majority of its mastectomy cases to the outpatient setting.

Shockney stresses that the ultimate decision is between the patient and her doctor. She fears, however, that legislation mandating inpatient coverage will block the development of new programs like that at Johns Hopkins:

"I hope that this legislation [mandated inpatient mastectomy coverage] doesn't discourage hospitals from developing such programs though, since this bill will make it easier for them to simply continue to provide care the "old way." The breast cancer patient isn't being done justice if hospitals continue doing this procedure the old way." [6]

(4) With the growth of physician-sponsored and hospital-sponsored health plans, mandated benefit laws will hurt many of the providers now advocating their passage. The National Association of Insurance Commissioners (NAIC) reports that 39 states have provider service organization (PSO) regulations and that PSOs are operating currently in 27 states. A PSO is a voluntary network of physicians and hospitals that both insures and provides health services under contract with health care purchasers. Physician and hospital groups have lobbied actively for federal preemption of state regulations and separate federal regulations of PSOs as they seek entree into the Medicare market. One reason for this is that PSOs find certain state mandated benefit laws burdensome and costly as they take on the new role of both provider and insurer. If Congress continues to enact health benefit mandates, however, PSO operators will find themselves increasingly facing the same costly requirements at the federal level that they are seeking to avoid at the state level.

(5) By singling out mastectomies or maternity care, politicians grant favored status to those suffering from a particular disease or disability, often responding to organized pressure rather than to medical priorities. Increasingly — and disturbingly — both the attention Congress pays to

medical issues and the actions it takes on those issues are determined by the political lobbying efforts of particular groups rather than by sensible medical priorities. In the case of mandates, of course, this lobbying is a result of a feeling among Americans that they are powerless in dealing with insurers. But the political "solution" favors those suffering from certain diseases at the expense of others afflicted with different diseases.

What is worse, Members of Congress overstep the bounds of their professional competence by determining not only the type of benefits, but also the duration and scope of those benefits. The politicians' penchant for playing doctor is summed up neatly by Washington Post columnist and trained physician Charles Krauthammer: "I am sorely provoked by the arrogance of a chamberful of lawyers stretching out its magic wand to anoint with special protection one, and only one, tragic affliction."[7]

The recent back-and-forth between Congress and the President (politicians) and the National Cancer Institute (scientists) regarding mammography screening standards shows just what can happen when politics and medicine are entwined. The NCI reported originally that "evidence does not support" the need for mammography screening for women under 50 years of age," but Congress, the Administration, and some advocacy groups were unconvinced. After much media attention and the passage of a congressional resolution indicating the displeasure of lawmakers, the NCI revised its guidelines. The only difference between mandating inpatient hospital coverage for mastectomies and passing a resolution that mammography screening should begin at 40 years of age—the efficacy and desirability of both of which are outside the scope of knowledge of most politicians—is one of degree. The question is not what the benefits or standards should be, but whether lawmakers are capable of making that deterrnination. The answer is that they are not: By politicizing the practice of medicine, politicians endanger patients.

DEALING WITH THE PROBLEM

The challenge for Congress is not to micromanage medicine, but to make it possible for Americans to walk away from a health plan that does not meet their individual needs and choose one that does. Members of Congress can do this thanks to the wide choice they have under the FEHBP. This power to "fire" their own insurer if they are dissatisfied is why Members of Congress rarely feel it is necessary to impose mandates on FEHBP plans. Changing the tax code to remove the financial penalties impeding choice for private-sector workers will give Americans real power over their own health insurers.

References

1 U.S. General Accounting Office, Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance, GAO/HEMS 96-161, August, 19, 1996.

2 Congressional Budget Office, letter to Congress, cost estimate of S. 969, Newborns' and Mothers' Health Protection Act of 1996, July 17, 1996.

3 Congressional Budget Office, memo to Congress, cost estimate of Mental Health Parity Amendments to VA/HUD appropriations bill, September 10, 1996.

4 U.S. General Accounting Office, Maternity Care: Appropriate Follow-Up Services Critical with Short Hospital Stays, GAO/HEMS 96-207, September 11,1996.

5 Statement of Dr. Janet M. Roberto on behalf of Concerned Women for America at congressional health care briefing, February 21, 1997.

6 Testimony of Lillie Shockney, RN, on behalf of Johns Hopkins University Hospital before Maryland state legislature, January 30, 1997.

7 Charles Krauthammer, "Play-Doctors on the Hill," The Washington Post, February 14, 1997.

ALLIANCE

Nell Williams
A-MASA President

Celebrate and Rededicate

Inaugural Speech, April 1997

I attended my first state Alliance meeting in Anniston in the Fall of 1990. I remember several things very distinctly from that meeting. Betsy Babb greeted us all so warmly at the registration desk; and there was a room full of people obviously happy to see each other. Antoinette Patterson was the President, and she ran that meeting beautifully. Another vivid memory was that when it was time to leave, my car wouldn't start because I'd left the lights on. Somebody had jumper cables and Helen Lee from Birmingham and Mary Ann LaFluer from Mobile (whom I had just met that morning) actually knew how to plug in the right connections so that I could bring a carload of folks back home to Birmingham. To my embarrassment, there are several photos of that scene in scrapbooks across the state!

But the most important thing I remember from that meeting was a quote Antoinette used from Pat Scofield's Inaugural Address. It was from Albert Schweitzer and it said, "It is not enough merely to exist. You must give something to your fellowman even if it is a little thing. Do something for someone who needs help for which you get no other pay except the privilege of doing." I think that is the reason I've continued to participate in this state organization.

The Alliance is a group which wants to give something back as evidenced by the county reports we heard yesterday. As I listened to those reports, I knew that any one of you could take this job on which I am about to embark and do it a great deal better. So I'm extremely proud to be able to serve with such a dedicated and talented group.

I know that sometimes we're discouraged when only a few people attend a well-planned program or when it takes several phone calls to fill a board position. And we realize there are many demands on everybody's time in this fast-paced society. But then we look at the numbers, and the bottom line is that many people are contributing, even if in a small way, and that together, we are indeed a strong and viable force.

We are people of diverse origins and experiences and we bring diverse talents; these all form a composite of

who we are and gives us a greater inclusiveness in the community. We can respect each other for our differences because we share common goals. And we nurture our sense of humor. I remember another past president, Carole Thomas, who ended her serious speech with the warning that "when the going gets tough, I'm going shopping."

I'm also pleased to be able to serve with you during the 75th Anniversary of the AMA Alliance as of June, 1997, and of the State Alliance and Jefferson County in early 1998. I hope you read the article on the history of the Alliance by our National President, Sandra Mitchell, in the Feb./March issue of *Newsline*. She pointed out that most of our work in the beginning was done through educating the public on health problems relating to hygiene, and the national publication which was called *Hygeia* was placed in schools and libraries. She says, "The Alliances' ability to educate and spread awareness has been our greatest strength."

An Anniversary is a time to celebrate and reflect on the past as well as to look ahead and plan for the future. So I've chosen for our theme this year, "Celebrate and Rededicate." I'd like to share some thoughts on that which I call "Celebrate and Rededicate."

Celebrate and Rededicate

(with apologies to Abraham Lincoln)

Four score minus five years ago, our forebears brought forth within this country, a new notion, conceived in love and concern, and presented before the American Medical Association House of Delegates, the proposition that we as physician spouses are dedicated to the health and welfare of our communities, that we should share in the education and care of those less fortunate, and that we promote acquaintanceships among doctors' families so that closer fellowship may exist".

Now Medicine is engaged in a great civil war, dividing doctor against doctor, spouse against spouse, and testing whether these notions may long endure. Hospitals, insurance companies, and HMOs are testing our strength of brotherhood and our dedication to a noble profession. We are caught in the midst of a great battlefield of that war. But we do not come to retreat!

We come today to celebrate a portion of our past - the 75th Anniversary of the American Medical Association Alliance - and to declare that this shall not be the final resting place of compassionate care and fellowship within the medical community. We come to celebrate the many good deeds that have been accomplished and to insure that the world will have fewer abused women and children, fewer guns in the hands of drug dealers, and more mammograms available in poor areas. We come to salute Camp Rapahope, Crysalis House, Childhaven, Children's Advocacy, Bodytrek, Someone to Talk To, and the various health screenings, immunization banks, and breast self-exam programs offered throughout our state and country. We come to make sure that the world will take note and well remember the voter registration drives, the anti-tobacco campaigns, and the anti-violence programs. We come to spread the news to young teens that the AMA's The Extinguisher is their true friend rather than the dangerous Joe Camel. And we come that we shall never forget to congratulate ourselves on the $50,000 raised locally and $2

Billion raised nationally to fund medical education and research.

But there is a great task remaining before us, that from these honored deeds, we take increased devotion to that cause which serves our fellowman. There is much unfinished work that lies before us so that ground now gained may be nobly advanced. There is immediate work to be done in the areas of Medicare reform, insurance reimbursement, and patient protection rights. There is continuing work in alerting the public to known health hazards, to offering options to victims of domestic violence, and to influencing federal laws on what is broadcast on the airwaves and internet. We must accept the notion that what we do or fail to do will affect many lives.

And, finally, we must rededicate ourselves as a group to present a UNITED STAND so that big business will not completely divide and thereby conquer what has been so laboriously built. We must face the future with a new resolve that the next 75 years will be even better and that we will honor our tagline,"Physician spouses dedicated to the health of America." We must rededicate ourselves, along with our spouses, to the notion that medicine will continue to serve all aspects of society, and that the historically-established and cherished physician-patient relationship shall not perish from this land.

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Book Review

Listen To Me Good: The Life Story of an Alabama Midwife
By Margaret Charles Smith and Linda Janet Holmes.
Ohio State University Press: Columbus, Ohio.
ISBN 0-8142-0700-6 1996 158 pages
Reviewed by David W. Hodo, M.D.

Listen To Me Good is the story of Mrs. Margaret Charles Smith, a remarkable Alabama woman. It recalls her career as a midwife in Greene County. In addition to her midwifery, Ms. Smith masters many other pursuits including sage, historian, friend, confidant, wife, mother, and farmer. The age of lay midwives and home delivery has passed. This book mourns that passing.

Mrs. Smith casts a large shadow, described as being over six feet tall. Her accomplishments equal her physical statue. At ninety years of age, she is still going strong on the lecture circuit.

She speaks eloquently to the care given by lay midwives who came to a person's home for a delivery and "stayed with women for as long as they are needed". Her appeal to natural medicine evokes an increasing appeal to many Americans exemplified by the best selling works of Dr. Andrew Weil.

It is a pleasure to read a book about our friends in Greene County, some of whom I know personally. I enjoyed discussing the book and the work of Mrs. Smith with Dr. Rucker Staggers at a recent reception at the Reynolds Historical Library in Birmingham. Dr. Staggers is described by Mrs. Smith as the physician "who stood behind me until the end." She says, "Dr. Staggers, he's so kind." Dr. Sandral Hullett plays a prominent role in the book.

I grew up in rural Alabama hearing stories of home births from a midwife who lived nearby. As a child, I was fascinated by her stories which seemed to rival the adventures of the novels of Zane Grey which I was reading at the time. This book represents an important slice of Alabama medical history. It is well worth reading.

Health Against Wealth: HMOs and the Breakdown of Medical Trust
By George Anders
Houghton-Mifflin, 1996, 299 pages.
Reviewed by Gregory A. Patton, M.D.*

Great societal forces are often mirrored by humor. You have probably by now heard some of the current jokes about health maintenance organizations (HMOs) which are making the rounds:

- HMO? It stands for Heave Mom Out.
- What is the difference between terrorists and an HMO? You can negotiate with terrorists.
- A certain physician succumbs to brief illness. When he reaches Heaven, St. Peter interviews him for admission

and asks the physician to recount what he had done with his life. "I worked for the largest HMO in America, making medical insurance available to the masses," boasts the doctor. St. Peter approves the physician's entry through the Pearly Gates, but only allows him a three-day stay.

Such humor is founded in an inherent suspicion and distrust of HMOs felt initially by the physicians caught up in the whirlwind of managed care but now also being appreciated by the lay public, those who are now coming to personally feel the effects of the HMO boom of recent years.

These fears are eloquently detailed in *Health Against Wealth: HMOs and the Breakdown of Medical Trust* by George Anders (Houghton-Mifflin, 1996, 299 pages). Anders is an investigative reporter for *The Wall Street Journal* who has covered for several years the worlds of medicine and money. His perceptive eye details both the strengths and weaknesses of HMOs.

He and his wife select their own health plan from a menu including a variety of options ranging from fee-for-service plans to preferred Provider organizations (PPOs) to HMOs. They have seen first-hand what happens when the medical/insurance system fails, while also appreciating the life-saving power of the right doctor at the right time.

He notes that millions of other Americans find themselves in the same situation as new health plans offering some form of "managed care" beckon to workers and retirees alike. Such plans are not only cheaper than traditional insurance, they also offer reduced paperwork and assurances that they can guard members against overtreatment.

But he appreciates that things are not quite that simple. The bottom line is that managed care plans save money by limiting patients' choices and installing overseers who restrain what doctors can do. He observes that there are too many instances in which lofty principles have been compromised or ignored on the way to the exam room or the patient's bedside.

Anders details case after disquieting case of care gone awry under the aegis of managed care:

A six-month-old baby who loses his hands and feet to complications of sepsis after a frenzied 42-mile trip to the HMO-approved emergency room for the area; HMOs which replace hospitalization and psychotherapy for psychiatric patients with medication to hold down expenses; drug formularies restricted to the least expensive medications irrespective of benefits of greater efficacy or fewer side effects among non-approved drugs; bitter battles to deny expensive therapies such as bone marrow transplantation to HMO breast cancer patients; HMOs which select hospitals with inferior success rates for cardiac surgery because of their lower costs.

The author perceptively pinpoints the Achilles heel of managed care: HMOs can be an efficient and cost-effective method of delivering routine or preventive care, but they are poorly equipped to handle the hardest part of medicine, namely taking care of sick people.

Current methods of measuring quality deal almost exclusively with the former since measuring Pap smear frequencies and mammogram rates is easy, while gauging success rates of caring for patients with heart attacks is much more complicated. The bottom line is that managed care is fundamen-

tally different from other industries in that its goal is to impose austerity on others.

Health plans are not directly accountable to either doctors or patients. The cynical view is that key to HMO profits is to get doctors to do what they are told and to keep patients in the dark. An HMO executive was quoted in the *Business Record* of Des Moines, Iowa in September, 1996: "We see people as numbers, not patients....We're a mass-production medical assembly line, and there is no room for the human equation in our bottom line. Profits are king."

Anders asks whether managed care can become more than just a ruthless way to cut costs. He observes that unless changes are made, important aspects of the health-care system may be in peril. The medical version of Gresham's Law, in which bad plans drive out the good, seems to be in play. He proposes several changes to improve managed care as practiced today:

1. Consumers need to make the managed-care system work for their own interests.

2. Doctors need to accept the principles of cost-effective medicine but be able to challenge specific managed-care rules without fear.

3. Doctors, employers, regulators, and HMOs need to combine forces to develop treatment guidelines that people can trust.

4. Regulators need to patrol the ways that HMOs pay doctors.

5. Regulators, doctors, and HMOs need to improve the rules for deciding tough cases.

6. Regulators and HMOs need to open up the emergency room.

7. Lawmakers and courts need to make HMOs accountable for their mistakes.

8. Consumers need to know how to file effective complaints.

9. Regulators need to keep the profit motive in check.

10. Employers, doctors, and regulators need to establish better report cards on the quality of health plans.

Anders predicts that at some point doctors will figure out how to run a cost-effective medical system without abandoning compassion, but at present the patient should be wary of patient care rhetoric which is too often an advertising gimmick. HMOs are at present a work in progress, and it remains to be seen whether they can ultimately balance the two diametrically opposed forces of health against wealth.

Barring such fundamental and necessary changes, HMOs threaten to become swashbuckling insensitive money machines profiting those whom Anders terms "The Barons of Austerity" and "The New Mandarins." As a result of the excesses and shortcomings of the present incarnation of HMOs, a backlash against HMOs and managed care is germinating among the lay public and practicing physicians. If you doubt this, check out the anti-HMO movement on the internet:

http://www.hmopage.org/

The HMO Page by Physicians Who Care (including such areas as Atrocity of the Month and the Hall of Shame); Fight Managed Care! (http://www.his.com/~pico/usa.htm) detailing 175 managed care horror stories, each providing eye-opening perspectives on the managed care revolution; or Adventures in Managed Care (http://members.aol.com/mcmdcomic/index.htm) in which comics depict the vagaries of managed care.

Witness also the ferment of managed care legislation, with 37 states (but not Alabama) having in 1996 passed laws or regulations governing some aspects of managed care. Such responses to the stimulus of managed care will not prevent its introduction, but will certainly greatly alter the shape of things to come. All is not well in HMO land.

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